AN EVALUATION OF A PARENT STRESS MANAGEMENT INTERVENTION FOR PARENTS OF CHILDREN WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

BY

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DECLARATION

I, Yashica Prithivirajh, hereby declare that the dissertation entitled "An evaluation of parents' perspectives of participating in a parent stress management programme for parents of children with Attention-Deficit/Hyperactivity Disorder" is the result of my own investigation and research an that it has not been submitted in part or in full for any other degree or to any other university.

Puthivirajh   27-05-2007

YASHICA PRITHIVIRAJH   **DATE**

FOR MY PARENTS

Merely saying "thank you" for all that you have done in making this study possible is not enough. I can never repay you for all that I have achieved because of you and all that you have done for me. That is why today, this dissertation is as much yours as it is mine. Thank you for your unconditional love, support and encouragement.

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ABSTRACT

A qualitative, phenomenological approach incorporating triangulation, process evaluative and appreciative inquiry techniques was used to evaluate parental experiences of participating in a stress management programme for parents of children with Attention Deficit Hyperactivity Disorder (ADHD). *Parents experienced the program as bringing about empowerment, group cohesion, cognitive restructuring, behaviour modification, growth, development and change.* Children viewed their parents as having become more relaxed, approachable, inclusive and loving. An independent psychologist evaluated the programme positively in terms of its quality, effectiveness, flexibility, adaptability and comprehensiveness. The research concludes with ways of improving the programme for future management of children with ADHD.

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CHAPTER I

INTRODUCTION

The purpose of this study was to evaluate the experiences of parents' participation in a stress management programme for parents with children diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD). The introduction to this study attempts to provide a brief summary on the background of ADHD, place it within the international and South African contexts, looking at its prevalence rates and its effects on parent-child interactions leading to parenting stress. The rationale, purpose, and methodology utilized to carry out this research are alluded to. Each chapter within this report is described at the end of this chapter under the heading: "Presentation of the Contents."

1.1 BACKGROUND OF ADHD

"They can't sit still; they don't pay attention to the teacher; they mess around and get into trouble; they try to get others into trouble; they are rude; they get mad when they don't get their own way" (Henker & Whalen, 1989, p.216).

ADHD is not a new disorder, the first record of a diagnosis of ADHD in the medical literature dates back to 1902 by George Still (Barkley, 1998). In 1902 in a series of three published lectures, Still described forty three children in his clinical practice who were often aggressive, defiant, resistant to discipline, excessively emotional, and who showed

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little inhibitory volition. Still was particularly impressed by the serious problems with sustained attention that these cases often manifested. Most were also quite overactive. Still believed that these children displayed a major deficit in moral control in their behaviour that was relatively chronic in most cases. He believed that these childrens' behaviours were due to some underlying neurological deficiency.

Later, Tredgold (1908) would also subscribe to this theory of early, mild and undetected brain damage to account for this disorder. Both Still and Tredgold found that temporary improvements in conduct might be achieved by alterations in the environment or by medications, but they stressed the relative permanence of the defect and emphasized the need for special educational environments for these children. These cases were not called ADHD, but symptoms consistent with ADHD were described.

In the 1940s it became fashionable to consider most children hospitalized in psychiatric facilities with hyperactive symptoms to have suffered from some type of brain damage, such as encephalitis or pre/perinatal trauma. The concept of the brain-injured child was to be born (Strauss & Lehtinen, 1947). This term would later evolve into the concept of minimal brain damage and, eventually minimal brain dysfunction (MBD) by the 1950s and 1960s.

The concept of "hyperkinetic reaction of childhood" was first termed by the medical classification system in 1968 and with it came the concept of the hyperactive child (Silver, 1999). Over the years the name has changed several times. In 1980, the term

"Attention Deficit Disorder" (ADD) emerged, that is, ADD with hyperactivity and ADD without hyperactivity. These days the term "ADHD" is the most recent diagnostic label for children presenting with significant problems with attention, impulsiveness, and overactivity (Barkley, 1998.)

Children sometimes seem to have boundless energy. They run, play, talk, laugh – and squirm, shout, have temper tantrums, interrupt others when they talk or don't want to share toys. It's just part of being a kid. But for some children, these actions are a sign of a behavioural problem called ADHD. When it was first identified, hyperactivity was defined principally as a problem of excess motor activity, and the term was used to describe children who could not sit still and were continually on the go (Siegelman & Rider, 2003). Now, hyperactivity is viewed as first and foremost a problem of attention.

Health professionals typically use the criteria listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR) as a guideline for determining whether someone has ADHD. This requires the presence of six or more symptoms of inattention, hyperactivity and impulsivity, these symptoms must develop before age seven, and they must significantly impair functioning in two or more settings (such as at home and at school) for a period of at least six months (American Psychiatric Association, 2000). Children, who meet the criteria for inattention, but not for hyperactivity/impulsivity, are diagnosed with Attention-Deficit Disorder (ADD) rather than ADHD.

1.2 PREVALENCE OF ADHD

Prevalence estimates of ADHD have ranged from 1-20% of the general population (Ross & Ross, 1982; Szatmari, Offord, & Boyle, 1989). However professional consensus is that approximately 3 to 5 % of the general child population will meet the criteria for some type of ADHD diagnosis (American Psychiatric Association, 1994). Boys are three to four times more likely to be diagnosed than girls (Zametkin & Ernst, 1999).

The number of children diagnosed and treated for ADHD has increased substantially, by some estimates, doubling in the 1990s (Santrock, 2002). In Australia, the Western Australia Child Health Survey (Zubrick, Silburn, Garton, Burton, Daldy, Carlton, Shepard, & Lawrence, 1995) found that attention problems were evident in 5.5% of 4 to 11 year-olds and 7.6% of 12 to 16 year-olds. Studies done in the United States and other countries, especially New Zealand and Germany, suggest that about 3-6% of the school-aged population has ADHD (Herrerias, Perrin, & Stein, 2001).

While some experts attribute the increased diagnosis of ADHD to heightened awareness of the disorder, others are concerned that many children are being diagnosed without undergoing extensive professional evaluation based on input from multiple sources (Santrock, 2002).

1.3 ADHD IN THE SOUTH AFRICAN CONTEXT

Attention Deficit and Hyperactivity Association of Southern Africa (ADHASA) says that ADHD is found in every ethnic and socio-economic group and is believed to affect about 10 percent of the South African population .

The recognition of culture and ethnicity are extremely important in the development of ADHD, as culture shapes the environment in which behaviour is defined as inattentive, impulsive or hyperactive. This is not to say that ADHD is just a matter of cultural definition. ADHD is defined as a neurologically based, genetically transferred, developmental disorder. As such, ADHD is expected to be present all over the world, but cultural norms and rules will modify how the disorder is manifested. It is therefore essential that the ethnic, cultural and language factors be taken into account in considering the development, manifestation, diagnosis and treatment of childhood disorders.

Research in Africa has been hampered by lack of resources, problems in access and communication, and political strife. In addition to differing cultural influences, African countries are faced with questions concerning differential diagnosis and co-morbidity when compared to Western countries (Madu, 2003). Tropical diseases like malaria and bilharzias, and consequences of malnutrition and hunger, may all lead to symptoms of inattention and/or restlessness, and thus methods for ruling out competing explanations should be developed (Madu, 2003).

Research among the different language groups in the Limpopo Province of South Africa indicates that ADHD is the most prevalent disorder also in South Africa and that the prevalence rates for ADHD subtypes are similar to Western rates for both genders in all language groups (Meyer, 1998; Meyer, Eilersten, Sundet, Tshifularo, & Sagvolden, 2002).

A study by Mako (2002) conducted in Gauteng, South Africa, revealed that there were no significant gender differences in the prevalence of ADHD symptoms in African children who were referred to a clinic for diagnosis and treatment, and those in the community. This may be an indication that the symptoms of ADHD in this particular sample may not be perceived as being pathological and therefore either be acceptable in their specific culture or be ascribed to other causes. The symptoms of ADHD may not be recognized and therefore no intervention will take place.

It also indicates the necessity for community workers and teachers to be trained in the identification of ADHD. Especially in predominantly African communities with an acute shortage of specialized services, a lack of general awareness of the disorders and their consequences, and possibly some tendency to deny or conceal their presence, the importance of community-based diagnostic services and instruments is undeniable (Madu, 2003).

1.4 PARENTING STRESS WITH CHILDREN WITH ADHD

Important indirect consequences of ADHD include effects on parent-child interactions and, more generally, the family environment. The problematic relationship between children with ADHD and their parents is best described as a "negative-reactive" response pattern. According to Johnston (1996), this pattern develops when parents of ADHD children react to their child's disruptive behaviours by displaying more commanding behaviour, more disapproval, fewer rewards for compliant behaviour, and more overall negative behaviour than parents of normal children. Kazdin and Whitley (2003) also found that the stress of the parent influences parent disciplinary practices which directly promotes and escalates aggressive and oppositional child behaviour, that is, the stress of parents appear to increase parent irritability and attention towards deviant child behaviour.

Current research on parenting and ADHD has revealed that ADHD has important consequences to the sufferers, as well as their parents and siblings (Swensen, Birnbaum, Secnik, Marynchenko, Greenberg, & Claxton, 2003). More specifically, there has been a discovery that parents experience greater stress with children with ADHD than other parents with children without ADHD, because of the additional parenting challenges they face (Rabiner, 2002).

The high levels of parenting stress associated with ADHD have been linked to maternal depression and marital discord, complicating an already difficult family environment

(Fischer, 1990). In turn, ADHD children raised in an environment characterised by negative parent-child interactions and family dysfunction have an increased risk for later substance abuse, criminality, and antisocial disorders (Hechtman, 1996; Klein & Mannuzza, 1991).

Based on these findings, researchers should explore treatments that reduce parenting stress and thereby reduce the risk for adverse outcomes.

1.5 RATIONALE

The researcher is an educational psychologist in private practice and has treated several children for ADHD. During her treatment of these children, what became apparent is that the parents of children diagnosed with ADHD are in urgent need of intervention. By the time these parents bring their children in for psychological intervention, because of school or academic difficulties, there are multiple problems. As Silver (1999) puts it: "When one member of a family is hurting, everyone feels the pain." The significant impairment experienced by children with ADHD, combined with their negative prognosis and impact on families, highlights the need for effective intervention and treatment.

There has been a movement from research on the epidemiology of ADHD to the parents and caregivers of children with ADHD over recent years, however, there is yet to be substantial research concentrated on the stress and more specifically tackling the

approaches parents have utilised to cope with the stress they experience from their child's disorder.

On reviewing the existing literature on parental stress associated with children who have been diagnosed with ADHD, only a few studies existed and all were conducted overseas. In South Africa there appeared to be a paucity of research on this topic. Also, all the research studies that have been conducted on parental stress with ADHD children were quantitatively analysed, with a clear scarcity of published literature that draws from parental experiences of parenting a child with ADHD (Anastopoulos, Shelton, DuPaul, & Guevremont, 1993; Weinberg, 1999; Wells, Epstein, Hinshaw, Conners, Klaric, Abikoff, Abramowitz, Arnold, Elliot, Greenhill, Hechtman, Hoza, Jensen, March, Pelham, Pfiffner, Severe, Swanson, Vitiello, & Wigal, 2000; Barkley, Guevremont, Anastopoulos, & Fletcher, 1992; Chronis, Pelham, Roberts, Gamble, Gnagy, & Burrows-Maclean, 1999; Treacy, Tripp, & Baird, 2005).

1.6 PURPOSE OF THE STUDY

The purpose of the present study was to explore and understand parents' experiences of participating in the Parent Stress Management programme for parents of children with ADHD. If the programme is effective in treating and managing parenting stress of the participants then it is hypothesized that the relationship between parent-child interactions would improve, resulting in more positive child-behaviours. This was investigated via a qualitative evaluation of the programme utilizing an appreciative inquiry methodology as

well as incorporating aspects of process evaluation. Based upon these informed observations, multidimensional treatment programmes can be recommended for families with children with ADHD.

1.7 CRITICAL QUESTIONS

The critical questions that framed this research were:

- What are the respondents' experiences of the Parent Stress Management Programme for Parents with Children Diagnosed with ADHD?

- What do the respondents appreciate about the Parent Stress Management Programme for Parents with Children Diagnosed with ADHD?

- How can the Parent Stress Management Programme for Parents with Children Diagnosed with ADHD be improved?

1.8 CONCEPTS USED IN THIS STUDY

Attention-Deficit/Hyperactivity Disorder (ADHD)

Children with ADHD present with significant problems with inattention, impulsiveness and overactivity (Barkley, 1998). Health professionals typically use the criteria listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Text Revision (DSM-IV) as a guideline for determining whether someone has ADHD. This

requires the presence of six or more symptoms of inattention, hyperactivity and impulsivity, these symptoms must develop before age seven, and they must significantly impair functioning in two or more settings (such as at home and at school) for a period of at least six months (American Psychiatric Association, 2000).

Parental Stress

In families of children with ADHD the characteristics of the child are thought to be the primary contributor to parenting and family stress (Anastopoulos, Guevremont, Shelton, & DuPaul, 1992). In what Johnston (1996) labeled a "negative-reactive" response pattern, parents of ADHD children display more directive and commanding behaviour, more disapproval, fewer rewards, and more overall negative behaviour than the parents of normal children do (Barkley, Karlsson, & Pollard, 1985; Befera & Barkley, 1984; Cunningham & Barkley, 1979; Mash & Johnston, 1982; Tallmadge & Barkley, 1983).

Family Systems Theory

The social-relations orientation to psychological counselling and therapy, unlike other orientations, has its principle focus on systems. A systems approach asserts the group and the family as its basis, rather than only the individual. From a systems perspective, there are various approaches to family therapy, namely: the Psychodynamic, Structuralist and Strategic approaches (Becvar & Becvar, 1996).

Family Stress Theory

The two models of stress theory that are appropriate for framing this research study are: the Reciprocal Interaction Model of Stress and Hill's ABCX Model of Family Stress as both of these models espouse a systems approach to stress and are relevant to the current study which is an evaluation of parents' experiences in a stress management programme for parents with ADHD children.

Phenomenology

Phenomenology requires methodologically, carefully, and thoroughly capturing and describing how people experience a phenomenon – how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others (Patton, 1987). To gather such data, requires subjects who have directly experienced the phenomenon of interest.

Triangulation

Using more than one data collection approach permits the evaluator to combine strengths and correct some of the deficiencies of any one source of data. Building checks and balances into a design through multiple data collection strategies is called triangulation. The triangle is the strongest of all geometric shapes, and triangulated evaluation designs are aimed at increasing the strength and rigor of an evaluation (Patton, 1987).

Process Evaluation

Process evaluations focus on gathering descriptive information about the quality of programme activities and outcomes, requiring qualitative data. Thus, to find out what it means to participate in a particular programme, is an issue of quality and it requires descriptions of the participants' perspective and situation such that the meaning of the experience for the participant is recorded (Patton, 1987). Process evaluation was utilized for this study and it was obtained via a session-by-session analysis of the programme.

Appreciative Inquiry (AI)

AI is a form of action research that attempts to create new ideas and images based on positive experiences that aid in the development of change in a social system. AI enables organizations to increase their capacity to make transformational shifts by moving organizations from a deficit- and problem -based approach to one where organizations learn from their most positive and successful experiences.

1.9 METHODOLOGY

The research approach was a qualitative one, namely phenomenology since the focus of this research study was on the experiences of participants in the intervention programme. Process evaluation techniques were utilised in order to evaluate the processes occurring

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during the course of the programme itself. This was achieved via a session-by-session evaluation of the programme by the researcher. The appreciative inquiry questionnaire was administered to all participants and a psychologist after termination of the programme. Confirming data was obtained from the ADHD children of participants via an interview with the researcher. All qualitative data was analysed using thematic content analysis and this was a post-test only design.

1.10 PRESENTATION OF THE CONTENTS

Chapter one: This chapter provides the introduction to this study, including information on the background, context, and prevalence rates of ADHD. Parenting stress with ADHD children is explored. The rationale, purpose and methodology utilized in this study are alluded to.

Chapter two: Reviews the relevant literature and studies pertaining to this research study, namely parent stress with ADHD children. Various theories on the causes of ADHD and parental stress will be presented and the theory that frames this study will be discussed.

Chapter three: This chapter provides a description of the research methodology, research instruments and the procedures employed to analyse the data yielded by this study.

Chapter four: Reports on the results and analysis of the data. An interpretation and discussion of the findings will be presented in this chapter.

Chapter five: This chapter concludes the study, indicates the limitations of the study and makes possible recommendations.

This chapter, chapter one, provided an introduction to this study, including information on the background, context, and prevalence rates of ADHD. Parenting stress with ADHD children was explored. The rationale, purpose and methodology utilized in this study were alluded to and finally, the presentation of the contents was provided. The following chapter, chapter 2, reviews the relevant literature and studies pertaining to this research study, namely parent stress with ADHD children. Various theories on the causes of ADHD and parental stress will be presented and the theory that frames this study will be discussed.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

The purpose of this study was to evaluate the experiences of parents' participation in a stress management programme for parents with ADHD children. This chapter provides an overview of the definition and theories on the causes of ADHD, theories on stress and parental stress with ADHD children and an understanding on why family systems stress theory has been utilized as the appropriate framework for this research project. This review is based on available international literature and not local literature due to the paucity of available literature on research conducted on the parents of ADHD children within the South African context.

2.2 WHAT IS ADHD?

Attention-Deficit/Hyperactivity Disorder (ADHD) is a chronic and debilitating disorder affecting 3% to 5% of school-aged children (American Psychiatric Association, 1994). Children with ADHD present with significant problems with inattention, impulsiveness and overactivity (Barkley, 1998). The Attention Deficit and Hyperactivity Association of Southern Africa (ADHASA) says that the condition is found in every ethnic and socio-

economic group and is believed to affect about 10 percent of the South African population.

Today more children than ever are being diagnosed as having ADHD. Two commonly asked questions are: **"Why is this?"** and **"Has it just become an excuse for children's inappropriate/unacceptable behaviours?"**

ADHD may be more commonly diagnosed today for several reasons

- We know more about ADHD and are better able to recognize it.

- The diagnostic criteria have changed over the years.

- We are not dealing with ADHD as well as we have done in the past (e.g. classroom sizes are bigger, less support from extended families, more TV and other technological distractions, less parenting – quantity and quality of time cared for in early years, pace of life, stress of life etc).

- Our expectations of children may have changed over time (e.g. in the past, it may have been more acceptable for active children who did not show an interest in school to leave at an early age to work in outdoor occupations, whereas nowadays, these children may be confined to classrooms for longer periods).

Attention-Deficit/Hyperactivity Disorder (ADHD) is usually first diagnosed in children and adolescents. It is characterized by inappropriate degrees of inattention, impulsivity and/or hyperactivity (Mehl-Madrona, 2003). Children with ADHD are typically:

- Impulsive
- Forgetful

- Restless to the point of disruption

- Bored

- Anxious

- Angry

Inattention is usually manifested in academic, occupational or social situations, with individuals having ADHD failing to give close attention to details or making careless mistakes at different tasks. Attentional problems at home are shown by failure to follow through on parental requests, and an inability to stick to activities. At school, inattention is usually evidenced by a failure to complete academic assignments. Hyperactivity may be manifested by fidgetiness, twisting in one's seat, an inability to remain seated when expected to, by being often "on the go", or by talking excessively. Impulsivity may be manifested by impatience, so that individuals with the disorder show difficulty in delaying responses or in awaiting their turn. At home, it is expressed by difficulty remaining seated during meals, or completing homework. In the classroom, it is evidenced by blurting out answers (Essau, McGee & Feehan, 1997 in Essau & Petermann, 1997).

Although many individuals present with symptoms of both inattention and hyperactivity-impulsivity, there are individuals in whom one or the other pattern is predominant. The appropriate subtype (for a current diagnosis) should be indicated based on the predominant symptom pattern for the past 6 months (American Psychiatric Association, 2000).

Attention-Deficit/Hyperactivity Disorder, Combined Type

This subtype should be used if six or more symptoms of inattention and six or more symptoms of hyperactivity-impulsivity have persisted for at least 6 months. Most children and adolescents with the disorder have the Combined Type.

Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type

This subtype should be used if six or more symptoms of inattention but fewer than six symptoms of hyperactivity-impulsivity have persisted for at least 6 months. Hyperactivity may still be a significant clinical feature in many such cases, whereas other cases are more purely inattentive.

Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type

This subtype should be used if six or more symptoms of hyperactivity-impulsivity but fewer than six symptoms of inattention have persisted for at least 6 months. Inattention may often still be a significant clinical feature in such cases. (American Psychiatric Association, 2000).

2.3 OTHER DIFFICULTIES

In addition to having problems with attention, hyperactivity and impulsiveness, children with ADHD often have what is referred to as associated difficulties. Comorbidity is found in as many as two thirds of the clinically referred children with ADHD (Dulcan, Dunne, Ayres, Arnold, Benson & Bernet, 1997). It is important to note that these are not symptoms of ADHD, but commonly occur along with the core symptoms. Social interactions and psychosocial development are adversely affected, thereby greatly reducing the child's quality of life (Anastopoulos, Guevremont, Shelton, & DuPaul, 1992). Not all children with ADHD will have all these difficulties, and they may vary according to the child's age and developmental level.

The frequency of co-occurrence is highest for Conduct Disorder and Oppositional Defiant Disorder, followed by Learning Disabilities, then Affective Disorders (e.g. Major Depressive Disorder, Bipolar Disorder, Mood Disorder, and Anxiety Disorder), and Tourette's Disorder with the lowest frequency of comorbidity (Barkley, 1997b; Biederman, Newcorn & Sprich, 1991). Allergies have also been found to co-occur with ADHD (Lensch, 2000).

The study by Biederman, Newcorn and Sprich (1991) reviewed the literature on comorbidity and findings on the co-occurrence with ADHD were as follows:

- Conduct Disorder co-occurs with ADHD in 30-50% of cases.

- There is limited research on co-occurrence of Oppositional Defiant Disorder, but it is frequently combined with Conduct Disorder.

- Mood Disorders, across studies, were found to co-occur with ADHD in 15-75% of cases.

- Anxiety Disorders have about 25% co-occurrence with ADHD and there is a higher incidence of ADHD in offspring of parents with Anxiety Disorder.

- There is a 10-92% reported co-occurrence of Learning Disabilities with ADHD.

- About 60% of youth with Tourette's Disorder also have ADHD. Conversely, only a small percentage of youth with ADHD have Tourette's Disorder.

Another pattern of social rejection also seems to appear in over half of all ADHD children because of their poor social skills. Even when the ADHD child displays appropriate or pro-social behaviour toward others, it may be at such a high rate of intensity that it elicits rejection and avoidance of the child in subsequent situations, or even punitive responses from his or her peers (Hinshaw, 1992; Ross & Ross, 1982).

At home, parents often complain that their ADHD children do not accept household chores and responsibilities as well as do other children their age (Barkley, 1998). Greater supervision of and assistance with these daily chores and self-help activities (dressing, bathing, etc.) are common and lead to the perception that these children are quite immature. Although temper tantrums are likely to decline, as they do in normal children, ADHD children are still more likely to emit such behaviour when frustrated than do normal children (Barkley, 1998). Relations with siblings may be tense, as the sibling

grows tired and exasperated at trying to understand and live with so disruptive a force as their ADHD brother or sister. Some siblings develop resentment over the greater burden of work they carry compared to their hyperactive siblings. Parents frequently find that they must intervene on behalf of their children to explain and apologise for their behaviour and transgressions to others, try to aid the children in coping better with the social demands, or to defend their children against sanctions that may be applied for their unacceptable behaviour (Barkley, 1998).

2.4 HOW IS ADHD DIAGNOSED?

The criteria for ADHD focus on behaviours that adults find frustrating and disruptive.

Few mental health professionals can recite the American Psychiatric Association diagnostic criteria as delineated in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) (American Psychiatric Association, 1994), even for the diagnoses they routinely use but the diagnostic standards are important in setting clinical and research trends. The existence of the diagnoses also influences how millions of parents and teachers view the children in their care. Most teachers and many parents of young people have heard of "hyperactivity" and, more specifically, Attention-Deficit/Hyperactivity Disorder (ADHD) (Breggin and Breggin, 1995).

The essential feature of ADHD is a persistent pattern of inattention and/or hyperactivity/impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development. Some

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hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years, especially in the case of individuals with the Predominantly Inattentive Type. Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (American Psychiatric Association, 2000).

2.4.1 DIAGNOSTIC CRITERIA FOR ADHD

According to the American Psychiatric Association (2000), the following criteria are necessary for diagnosing ADHD:

A. Either (1) or (2):

(1) six or more of the following symptoms of **inattention** have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

INATTENTION

(a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.

(b) Often has difficulty sustaining attention in tasks or play activities.

(c) Often does not seem to listen when spoken to directly.

(d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)

(e) Often has difficulty organizing tasks and activities.

(f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).

(g) Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools).

(h) Is often easily distracted by extraneous stimuli.

(i) Is often forgetful in daily activities.

(2) six or more of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

HYPERACTIVITY

(a) Often fidgets with hands or feet or squirms in seat.

(b) Often leaves seat in classroom or in other situations in which remaining seated is expected.

(c) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).

(d) Often has difficulty playing or engaging in leisure activities quietly.

(e) Is often "on the go" or often acts as if "driven by a motor".

(f) Often talks excessively.

IMPULSIVITY

(g) Often blurts out answers before questions have been completed.

(h) Often has difficulty awaiting turns.

(i) Often interrupts or intrudes on others (e.g., butts into conversations or games).

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment are present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school or work and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

The diagnosis must be made on a number of observations, since ADHD is not a defined biological entity, but a collection of symptoms and behaviours. Typically, parents and teachers complete questionnaires, children are observed at home and at school, psychological tests are administered, and a clinical interview of the child and the family is conducted.

One assessment tool is the use of behavioural rating scales in the identification of ADHD. The Conners' Teacher's Rating Scale (CTRS), developed in 1969 by C. Keith Conners, has been used extensively since its publication. This instrument is important because of its wide acceptance. The CTRS has been in use for about 25 years.

Although our understanding of ADHD has changed over the years, the preference for the scale has continued to be stable. The CTRS has a 4-point scale. It includes the following ratings: Not at all present, Just a little present, Pretty much present, and Very much present. There are 28 items in the scale with several questions that collect demographic information from the respondent. Both the child's teacher and a parent complete the scale. A discrepancy score should be determined from the two completed questionnaires to determine whether the child is exhibiting ADHD symptoms (Mehl-Madrona, 2003).

Other rating scales include the Conners Abbreviated Symptoms Questionnaire (ASQ), developed by C. Keith Conners in 1969. This 10-item scale is often used for screening purposes to identify hyperactive children. Being a rating scale, it is rather leading with the result that school teachers in the school context often exaggerate symptoms for children they would prefer to be quieter and more co-operative. Clearly, an evaluation should integrate multiple informants and look at the child in a comprehensive manner since no single test can effectively diagnose the disorder.

2.5 THE THEORIES OF THE CAUSES OF ADHD

Once parents become aware that they have a child or adolescent with ADHD and have accepted this reality, they inevitably ask, "How could this have happened? Why me?" They believe that if they knew what causes ADHD, they would know how to cure it. Or they might be looking for something to blame for the problem or something to avoid so that it won't happen to someone else in the family (Silver, 1999).

Unfortunately, no one has yet determined the cause for ADHD. Most research suggests that for most individuals something influenced the brain during pregnancy, probably early in pregnancy (Silver, 1999). In about 50% of affected children, research shows it is the genetic code that "tells" the brain to wire itself differently, that is, these problems run in the family. When there is a family history with another sibling, mother or father, or extended family member having ADHD and/or learning disabilities, it is easier to make an assumption on the cause, which points to a hereditary factor (Biederman, Faraone,

Keenan, Benjamin, Krifcher, Moore, Sprich-Buckminster, Ugaglia, Jellinek, Steingard, Spencer, Norman, Kolodny, Kraus, Perrin, Keller, & Tsuang, 1992).

For several decades, ADHD has been thought to involve brain damage, and this notion is reflected in the previous use of labels such as "minimal brain damage" or "minimal brain dysfunction" (Ross & Pelham, 1981). In recent years, our scanning technology has permitted a sophisticated assessment of the validity of this assumption. Two areas of the brain, the frontal cortex (in the outer portion of the brain) and the basal ganglia (deep within the brain), recently have been associated with ADHD; specifically, a relative lack of activity in these areas has been observed in people with ADHD (Zametkin, Nordahl, Gross, King, Semple, Rumsey, Hamburger, & Cohen, 1990). Other evidence suggests that portions of the right hemisphere may be malfunctioning (Riccio, Hynd, Cohen, & Gonzalez, 1993) and that frontal lobe development and functioning also may be abnormal (Giedd, Castellanos, Casey, Kozuch, King, Hamburger, & Rapport, 1994).

A variety of toxins such as allergens and food additives have been considered as possible causes of ADHD over the years, although very little evidence supports the association. The theory that food additives such as artificial colours, flavourings and preservatives are responsible for the symptoms of ADHD has had a substantial impact. Feingold (1975) presented this view along with recommendations for eliminating these substances as a treatment for ADHD. Many families have put their children on the Feingold diet, despite evidence that it has little or no effect on the symptoms of ADHD (Barkley, 1990).

Psychological and social dimensions of ADHD further influence the disorder itself. Negative responses by parents, teachers and peers to the affected child's impulsivity and hyperactivity may contribute to his or her feelings of low self-esteem (Barkley, 1989). Years of constant reminders by parents and teachers to behave, sit quietly and pay attention may create a negative self-image in these children, which, in turn, can have a negative impact on their ability to make friends. Thus, the possible biological influences on impulsivity, hyperactivity, and attention, combined with attempts to control these children, may lead to their being rejected and to consequent poor self-image (Barlow & Durand, 1999).

What causes ADHD? There is no single answer. In many cases, there are several factors thought to be associated with ADHD. These factors are both genetic and environmental. These include:

- genetic and hereditary factors

- neurobiological conditions and pathologies

- prenatal influences

- nutritional factors and deficiencies

- environmental/toxin influences

(Zametkin; Nordahl, & Gross, 2000)

Health professionals stress that since no one knows what causes ADHD, it doesn't help parents to look backward to search for possible reasons. There are too many possibilities to pin down the cause with certainty. Scientists, however, do need to study causes in an

effort to identify better ways to treat, and perhaps someday, prevent ADHD. They are finding more and more evidence that ADHD does not stem from the home environment, but from biological causes. When you think about it, there is no clear relationship between home life and ADHD. Not all children from unstable or dysfunctional homes have ADHD. And not all children with ADHD come from dysfunctional families. Knowing this can remove a huge burden of guilt from parents who might blame themselves for their child's behaviour (Point, 2003)

ADHD IS NOT USUALLY CAUSED BY:

- too much television

- food allergies

- excess sugar

- poor home life

- poor schools

(Point, 2003)

We know a lot. We also know very little. We understand many possible causes of ADHD. We do not have a definite answer yet. Until we do, we cannot speak in terms of prevention or cure, only for hope of preventive efforts and better treatments

2.6 TREATMENT OF ADHD

The treatment of ADHD must be multimodal – involving several approaches. These approaches include individual and family education, individual and family counseling, the use of appropriate behavioural management programmes, and the use of appropriate medications. Each approach requires working closely with the school (Silver, 1999). It has been established that children with ADHD have high rates of co-morbidity and dysfunction in many areas. Numerous studies have looked at the most effective treatment modalities. The stimulants certainly address attention and concentration, and have been shown to be equally effective in decreasing the aggressive behaviours frequently associated with children with ADHD. Behaviour therapy also continues to play an extremely important role in ADHD treatment for all subtypes. Studies have shown that it has an additive effect to medication treatment.

Because of the high rate of co-morbidity with ADHD children, as well as many different aspects of the child's life potentially affected by the disorder, it is critical to look at each child individually. After examining how ADHD affects this particular child, it is then necessary to understand how this child functions in the different worlds he or she must operate in, such as family, school, social and chosen activities. Evaluating a child's functioning, as influenced by multiple motivating factors, assists in determining his or her personal strengths and weaknesses. In this regard, the behavioural treatment plan which capitalizes on the child's strengths to reinforce self-esteem, is the perfect complement to medication treatment (Fiore, Becker & Nero, 1993).

2.6.1 MEDICAL INTERVENTION

Since the use of stimulant medication with children with ADHD was first described (Bradley, 1937), hundreds of studies have documented the effectiveness of this kind of medication in reducing the core symptoms of the disorder. It is estimated that 85-90 percent of learners with ADHD are taking stimulant medication such as Methylphenidate to control their behaviour (Santrock, 2002). These drugs have proven to be helpful for approximately 70 percent of cases in temporarily reducing hyperactivity and impulsivity and improving concentration on tasks (Cantwell, 1996). Originally, it seemed paradoxical or contrary to expect that children would calm down after taking a stimulant, however, in many children with ADHD, it slows down their nervous system and behaviour (Johnston & Leung, 2001). Methylphenidate enables ADHD children to better focus their attention and makes them less distractible and disruptive. Important side benefits of this increased attentional focusing are that both academic and peer relations are likely to improve (Pelham, Carlson, Sams, Vallano, Dixon, & Hoza, 1993).

Although the use of stimulant medication remains controversial, especially for children, in combination with psychosocial interventions, they help to improve children's social and academic skills (Pelham & Milich, 1991). In addition, the medications often result in unpleasant side effects such as insomnia, curbing appetites, drowsiness or irritability (DuPaul, Anastopolous, Kwasnik, Barkley & McMurray, 1996).

South Africa has its own share of sceptics about treating ADHD with drugs. The Style magazine carried an article in October 2006 entitled "Generation R" (Roberts, 2006). The article reports that medical professionals, parents and even schools all have different approaches to a disorder that has increased in prevalence. About six percent of South African school-goers have been diagnosed with ADD/ADHD. Professor Tian van der Merwe of the Medical University of Southern Africa's faculty of medicine believes that doctors are too easily prescribing drugs such as Methylphenidate before looking at other possible causes and preventions for ADD/ADHD. However, he points out that parents can also be to blame. "Doctors are trained to look at medication first, and so they do," he says. "In addition, we live in a very busy world where there is less time and more stress so parents want quick answers such as Methylphenidate, sometimes it is the parents who pressurize the doctor for medication for their child."

Dr. David Benn is a child psychiatrist at Johannesburg's ADDNova centre. He has worked extensively on the treatment of children with ADD/ADHD for more than two decades and has played a significant role in bringing the subtler Ritalin alternative, Strattera, to South Africa. "Not everyone with ADD/ADHD needs to be on medication and there is no doubt that drugs such as Methylphenidate are over-prescribed," he says (Roberts, 2006). "Making a diagnosis is quite difficult because you need to know in what environment the child is displaying his or her symptoms. Also, despite the amount of research done on genetics, brain structure and biochemistry, there is still no reliable test for ADD/ADHD. There may never be, simply because it is a group of disorders that all look similar to each other."

"The tendency in some schools is to find a quick solution to a problem a child is having. We live in a highly diagnosed society. In the past, the cane was seen as the cure for discipline but now something else has had to be found. There is a reliance on ADD/ADHD as the defining reason for a child's misbehaviour and Methylphenidate is the quick-fix" (Roberts, 2006).

2.6.2 BEHAVIOUR MODIFICATION

Behaviour modification, particularly the use of consequences, is the most commonly practiced classroom intervention for students with ADHD (Pfiffner & Barkley, 1990). In general, the programmes set such goals as increasing the amount of time the child remains seated, the number of maths papers completed, or appropriate play with peers. Reinforcement programmes reward the child for improvements and, at times, punish misbehaviour with loss of rewards (Braswell & Bloomquist, 1994). Time-out is a condition in which an individual is removed from a reinforcing situation, such as removing the child from the group to sit in the passage or in a quiet chair until he is ready to rejoin the group (Bos & Vaughn, 1998). Although this approach may affect the target behaviours, there may not be a corresponding improvement in academic performance (Barkley, 1990; Zentall, 1989). Additionally, because the teacher externally controls the intervention, it is usually effective only within that specific environment and as long as the teacher is using the procedure (Zentall, 1989).

Behavioural approaches to treatment of ADHD is considered the most effective non-pharmalogical intervention (Hinshaw, Klein & Abikoff, 1998). Research shows that clinical behaviour intervention procedures such as parent training demonstrate statistically significant benefits with regard to ADHD-related problem behaviours (Barkley, Guevremont, Anastopolous & Fletcher, 1992; Pisterman, Firestone, McGrath, Goodman, Webster, Mallory & Goffin, 1992; Anastopolous, Shelton, DuPaul & Guevremont, 1993).

Few studies in the literature report on the effects of behavioural interventions on parenting stress among the parents of children with ADHD (Anastopoulos et al., 1993; Pisterman, McGrath, Firestone, Goodman, Webster, Mallory, & Goffin, 1992; Weinberg, 1999; Wells et al., 2000). Both, Anastopoulos et al. and Pisterman et al., reported improvements in parenting stress and perceived parenting competence/self-esteem following parenting training. Weinberg reported an increase in parents' knowledge of ADHD and a modest decrease in parental stress. Wells et al .(2000) report small changes in parenting stress across all four treatments, medication, beavioural, combined, and community care.

2.6.3 COGNITIVE-BEHAVIOURAL THERAPY

Typically, cognitive-behavioural therapies include strategies that are designed to enhance self-control through self-regulatory processes (Barkley, 1997). Self-regulation includes

actions taken by an individual for the purpose of altering one's own behaviour and consequently, the outcome. Methods of accomplishing this change in outcome usually involve self-directed activities beginning with having the individual observe his or her own behaviour as it is essential to recognize the inappropriate behaviour before attempting to change it (DuPaul & Stoner, 1994; Copeland & Love, 1995).

Self-monitoring can be used to identify and record maladaptive behaviours when they occur. Usually, an external cue is implemented initially, as in behaviour modification, possibly in the form of a signal from the teacher. However, in cognitive-behavioural modification, the external cue is faded out after the subject has internalized the ability to self-monitor (Meichenbaum, 1977). Through the paired use of cuing and modeling, the responsibility for changing behaviour is transferred from an external source (e.g. parent or teacher) to the internal mechanisms of the student .

Self-monitoring within educational research has two main foci, that is, time-on-task (amount of time the student continues working on the task) and cognitive behaviour (actual time the student spends solving the problem or completing the task) (Goldstein & Goldstein, 1990).

Only two studies have directly targeted the distress of parents of children with ADHD. Barkley, Guevremont, Anastopouos, and Fletcher (1992) found that both cognitive-behavioural family treatment (problem solving and communication training) and behavioural parent training reduced depression scores in mothers of adolescents with

ADHD. More recently, Chronis, Pelham, Roberts, Gamble, Gnagy, & Burrows-Maclean (1999 in Treacy, Tripp, & Baird, 2005) tested the effectiveness of Lewinsohn's Coping with Depression Course in a wait-list control study with the mothers of children with ADHD. Treatment was associated with less depressive attributions for negative child behaviour, improved self-esteem, and, for those with at least mild depressive symptomatology, a decrease in depression post-treatment.

2.6.4 ACADEMIC INTERVENTIONS

Once the diagnosis of ADHD is established, it is important to work with your son's or daughter's classroom teacher(s) as well as with the school system. Your goal is to create the best classroom environment as well as to clarify what services or accommodations your child might need. Hopefully, the use of appropriate medication will minimize or stop the child's hyperactivity, distractibility, and/or impulsivity. If so, the classroom teacher needs to understand the medications, their schedule, how they work, what side effects might occur, how to observe the student's behaviours, and how to communicate with the clinician managing the medications (Silver, 1999).

In Silver (1999), there are four aspects of the regular classroom that should be addressed: establishing the best learning environment, giving instructions and assignments, modifying unacceptable behaviours, and enhancing self-esteem.

2.6.4.1   ESTABLISHING THE BEST LEARNING ENVIRONMENT

The classroom should be modified to address the child's ADHD behaviours. The student should be surrounded with good role models, preferably students who will not get pulled into inappropriate behaviour. The classroom should be calm, quiet and organized as is possible for the grade. The student will also need additional structure and supervision during out-of-the-classroom time (e.g. at lunch, in the hall, on field trips) and all teachers should be informed of the child's special needs.

2.6.4.2   GIVING INSTRUCTIONS AND ASSIGNMENTS

When giving instructions and assignments, the teacher should be sure to have the student's attention and to make the information clear and concise. There should be consistency with daily instructions and expectations. The teacher should be sure that the student understood the directions before beginning the task, if necessary, instructions must be repeated by the teacher. A daily assignment notebook might be helpful.

2.6.4.3   MODIFYING UNACCEPTABLE BEHAVIOURS

Rules of the classroom should be clear and understandable. If the student breaks a rule, the teacher should remain calm, state the infraction, and avoid debating or arguing with

the student. Having pre-established responses and consequences for inappropriate behaviours is helpful. The teacher must avoid criticism and ridicule.

2.6.4.4 ENHANCING SELF-ESTEEM

Building or rebuilding self-esteem is important. The teacher should reward the student more than punish. Any and all good behavior and performances should be praised immediately, and emphasis should be on encouraging the student.

It is important that parents work closely with the classroom teacher and with the school professionals who must develop the most appropriate school environment and programme for the student with ADHD. To be informed and assertive advocates that parents understand both, the needs of their son or daughter and his or her right to specific services or accommodations.

2.6.5 SOCIAL SKILLS TRAINING

Most children with ADHD experience difficulty getting along with parents, peers, siblings and teachers (Frederick & Olmi, 1994). Social skills needed for social competence include physical factors (such as eye contact and posture), social responsivity (such as sharing), and interactional skills (such as initiating and maintaining conversation). In addition, some children with ADHD do not appear to be able to read social cues such as the look on the face, the tone of voice, or body language. Before a

child starts in a social skills group, it is important to identify the individual's area of social incompetence and the specific skills that appear to be missing (Silver, 1999).

There are many programmes described in the literature for doing social skills groups. The general focus is on a series of steps (Silver, 1999). The first step involves helping the child develop a sensitivity for his or her social problems. The second step involves having the child generate alternative solutions for the identified problems. The third step involves helping the child step-by-step through the process of learning the newly identified solution to the problem. The final step is to help the child link the new knowledge to past events and difficulties as well as to future events.

2.6.6 PSYCHOTHERAPY

Psychotherapy might include therapy for the child on his/her own or with other children in a group. The purpose of psychotherapy is to enable a child to recognize and understand his or her feelings and to learn to deal with them more appropriately (Wender, 2000). The professional looks at the interactions between internal thinking processes (basic wishes and needs, conscience or value system, and the ability to assess the realities of the outside world). The clinician explores the relative strengths of each process, the coping skills available to handle any conflicts between these processes (called defense mechanisms), and whether the conflicts and strategies are age-appropriate and successful.

2.6.7 PARENT TRAINING

Parent training is often employed in the clinical management of ADHD, either alone or in combination with other intervention techniques (such as medication). An individual parent might need help with his or her own feelings of inadequacy and failure as a parent. He or she might be depressed or might be made to feel so helpless that anger becomes the only response. The two parents might feel overwhelmed as a parenting team. They might disagree on parenting styles and behavioural strategies. If there had not been stress in the marriage, it might develop (Silver, 1999).

Various training programmes exist, but all strive to promote more positive, compliant, and generally pro-social behaviour while decreasing negative, defiant, and disruptive behaviour in children. Typically, this is achieved by training parents in more positive, consistent, and predictable child management skills (Forehand & Mcmohan, 1981; Patterson, Dishion, & Reid, 1992; Webster-Stratton & Spitzer, 1996).

Depending on the types of difficulties found with each parent, individual therapy for one parent, couples therapy relating to behavioural management approaches, or couples therapy relating to marital stress might be needed.

2.6.8 DIETARY INTERVENTION

Professionals who work with children have reported for many years that they see a higher percentage of children in their practice with allergies who also have learning disabilities and/or ADHD (Silver, 1999). From several studies conducted on the possible relationship between allergies and learning disabilities, there does appear to be a relationship between allergies and brain functioning. No specific cause and effect has yet been clarified.

In 1975, Dr. Benjamin Feingold published a book, "Why Your Child Is Hyperactive." He proposed that synthetic flavours and colours were related to hyperactivity and by eliminating all foods containing artificial colours and flavours as well as salicylates (a chemical related to aspirin), hyperactivity would stop. A diet that eliminates these chemicals is called a food-additive-free diet or Feingold diet. To date, no research projects have come up with any research data to support this theory.

2.7 IS THERE A BEST APPROACH?

In the National Institute of Mental Health Multimodal Treatment of ADHD Disorder Study (Jensen, Hinshaw, Swanson, Greenhll, Conners, Arnold, Abikoff, Elliot, Hechtman, Hoza, March, Newcorn, Severe, Vitiello, Wells, & Wigal, 2001), a comparison was made between children who received optimally delivered medication, state of the art behavioural treatment (a combination of parent training, child training through a summer programme, and a school intervention), a combination of the two

approaches, or routine care in the community. The findings were clear: medication alone is more effective than behavioural treatment alone or routine care in reducing ADHD symptoms. However, a combination of medication and behavioural treatment was superior to medication alone when the goal was defined as not only reducing ADHD symptoms, but also improving academic performance, social adjustment, and parent-child relations.

Yes, medication is indeed effective in enabling children to concentrate for longer periods of time and to learn better but it does not usually stop all 'naughty' behaviour. The worst aspects of a child's behaviour may escape the impact of the medication because they have become deeply ingrained habits. Medication cannot teach skills and rules, what they can do, though, is calm children down so that they can learn more easily (Pentecost, 2000). Medication, combined with both, behavioural programmes designed to teach children with ADHD to stay focused on tasks and to control their inappropriate behaviours, and parent training designed to help parents understand and manage the behaviour of their children, is seen as the most effective and successful treatment plan for ADHD children.

2.8 STRESS

There have been many different definitions of what stress is, whether it is used by psychologists, medics, management consultants, or others. Reviewing the vast literature available on stress, there seems to have been something approaching open warfare between competing definitions of stress. What complicates this is that intuitively we all

feel that we know what stress is, as it is something that we have all experienced. Everyone has stress in their lives. Stress can help people make the most of opportunities and what they do, or it can cause health problems. We all realize that stress occurs in our lives every day. Sometimes it feels like the demands that are placed on us are overwhelming. We feel like "checking out" when our minds and emotions are on overload (Kendall, 1998). A definition should therefore be obvious, except that it is not.

2.8.1 THE CONCEPT OF STRESS

One problem with a single definition is that stress is made up of many things: It is a family of related experiences, pathways, responses, and outcomes caused by a range of different events or circumstances. Different people experience different aspects and identify with different definitions.

Hans Selye (one of the founding fathers of stress research), identified another part of this problem when he saw that different types of definition operate in different areas of knowledge (Neylan, 1998). Selye's view in 1956 was that "stress is not necessarily bad – it all depends on how you take it. The stress of exhilarating, creative, successful work is beneficial, while that of failure, humiliation or infection is detrimental" (Selye, 1976). Selye believed that the biochemical effects of stress would be experienced, irrespective of whether the situation was positive or negative (Neylan, 1998).

The traditional view is that stress is a set of demands on individuals that tax or exceed their resources for managing them. There is another view of stress that is emerging that is in contrast to the concept of stress as overload. Though no longer new, this more recent, cognitive view of stress focuses on "interruption" and subsumes the idea of overload (Mandler, 1982). The basic premise of interruption theory is the well-documented finding that autonomic activity (distress or anxiety) results whenever some organized action or thought process is interrupted. Interruption is the disconfirmation of an expectancy or the non-completion of some initiated action. The autonomic activity instigated by interruption (stress) serves as a signaling system that demands attention. This can result in the adaptive response of increasing attention to crucial events or, in more extreme situations, of drawing attention away from other needed areas (Baddeley, 1972). This view of stress from interruption theory relates very well to an identity theory approach to stress as well as to the understanding of stress processes as described by sociologists (e.g. Pearlin, Lieberman, Menaghan, & Mullan, 1981; House & Harkins, 1976) as well as some psychologists (e.g. Higgins, 1989).

2.8.2 THEORIES AND MODELS OF THE STRESS PROCESS

2.8.2.1 IDENTITY THEORY MODEL OF STRESS

When an identity is activated, identity processes operate continuously through time to maintain congruence between the identity standard and reflected self-appraisals. The identity standard is a set of expectancies in the form of meanings, and the output of the

identity system (meaningful behaviour) is linked to its input (perceived self-meanings) primarily through the social environment. An identity process is a continuously operating, self-adjusting, feedback loop: individuals continually adjust behaviour to keep their reflected appraisals congruent with their identity standards or references. In familiar situations, this adjustment process is nearly automatic, requiring little or no attention. Since the identity process is continuous, the amount by which one's reflected appraisals differ from one's identity standard is kept small. The existence of a relatively large discrepancy is likely to indicate some type of interruption in the identity process that has suspended the normal condition of continuous congruence between reflected appraisals and the identity standard (Stotland & Pendleton, 1989)

As the incongruence between one's reflected appraisals and one's identity standard is created and grows beyond the minimal discrepancies that are handled automatically (or perhaps ignored), first, one's attention is directed to the discrepancy as the identity process is brought under conscious control (Shlenker, 1987). If the incongruence increases distress increases providing both, an alarm system and motivation to remediate the problem discrepancy (Young, 1988).

To the extent that an identity is well established, there is better organization of the feedback process. In addition, the more salient the identity, the more important is the process. Both of these conditions, organization and salience, are important. Interruption theory suggests that the interruption of more organized and salient processes (such as

identity processes) leads to the heightened autonomic activity experienced as distress (Mandler, 1982).

2.8.2.2 BROWN'S IDENTITY DISRUPTION MODEL OF STRESS

The model of identity theory presented above is most similar to Brown's identity disruption model (Brown & McGill, 1989) which suggests that the negative effects of life events operate through the process of creating alterations in self-concepts – alterations that have a negative impact on health. According to Brown & McGill (1989), there is a two step process in which life events first create a change in a person's identity and then the identity disruption has a negative impact on health. They suggest four ways in which the first step may occur. A life event may cause an individual to abandon an existing identity (e.g. through the death of a spouse or the loss of a job). A life event may cause an individual to adopt a new identity as when that person becomes married or joins the labour force. A third form occurs when life events disrupt an identity by changing the structure of the self-concept. An example would be a son or daughter leaving home. The last form of impact occurs when life events cause a person to re-evaluate an existing identity, for example, when a job loss causes a person to question their identity as a successful business person.

With respect to the second step wherein identity disruption has a negative impact on health, Brown & McGill (1989) suggest that since identities function to facilitate the processing of personal information (Markus, 1977), to provide guidelines for present and

future behaviour (Gergen, 1971; Markus & Nurius, 1986) and to act as the basis for people to react to each other (Swann, 1987), any disruption of identities would cause people to have to devote extra attention to these tasks, thus depleting energy and resources that might be used elsewhere. Such depletion of resources may thus limit a person's ability to withstand illness. Additionally, with the disruption of an identity, the utility of that identity for predicting and controlling events is diminished, and such loss of control may also have negative health consequences.

Life Events: Type I Interruptions

Holmes (Holmes & Rahe, 1967; Holmes & Masuda, 1974) hypothesized that events that disrupt habitual activities and demand adjustment to new states would be the source of social psychological stressors leading to the same physiological distress reactions as observed by Selye. It was the contention of Holmes and Rahe that the important factor was change itself, apart from its meaning or direction, not whether the change was culturally good or bad, desirable or undesirable. The central focus in Type I Interruptions is not whether events themselves are controllable or not as suggested by several writers (Thoits, 1983; Dohrenwend, 1973; Grant, Sweetwood, Yager, & Gerst, 1983). Rather, the question is the loss of control by an individual over events that are part of the identity maintenance process. Examples of Type I Interruptions include: the loss of identity or the loss of the sense of self ("it's as if I don't exist"), which is the source of distress identified by Stein, Vidich, and White (1960). This type of interruption includes distress associated with the loss of a job (Gross, 1970), or the loss of a loved one (Croog, 1970).

Role Conflict and Status Inconsistency: Type II Interruptions

Role conflict has been defined in a number of ways in the literature, although most definitions distinguish intra-role conflict and inter-role conflict. The former exists when a person in a particular role position is confronted with incompatible expectations from his or her performance in that position. The latter exists when a person occupies two different roles that have conflicting expectations for behaviour (Stryker & Macke, 1978). As formulated by Lenski (1954), American social structure is characterised by a number of status dimensions that are not equivalent. Sometimes referred to as class, status and power, the dimensions have usually been operationalised by education, occupation and income (or sometimes race). Since people can have different ranks on each of these status dimensions the argument runs, they may have inconsistent expectations held for them based on their education (which may be high) and their occupational prestige (which may be low).

Type A Personality and Other Highly Controlled Identities: Type III Interruptions

Type III interruptions with their consequent distress occur in the "tightly" or over-controlled identity. A tightly controlled identity is likely to lead to greater frequency and higher levels of distress. Individuals who have a tightly controlled identity must monitor and adjust their identity process frequently, and because conscious attention is limited, this frequent adjustment can interrupt other processes or be interrupted by other

processes. These frequent interruptions by the process itself are associated with distress (Shapiro, 1992). Type A persons are impatient with delay and react with annoyance and impatience when completion of task is delayed (Glass, Snyder, & Hollis, 1974).

The most commonly accepted definition of stress these days (mainly attributed to Richard. S. Lazarus) is that stress is a condition or feeling experienced when a person perceives that demands exceed the personal and social resources the individual is able to mobilize (Miller, 1998). This experience involves physiological, psychological, and behavioural processes.

Stress is a feeling of tension and excitement or pressure to do well which alerts the body to be ready to put a big effort into whatever a person is doing. Stress can come, for example before a race or exams, when there is a lot to do at work or home, or a special thing to do, or when there is something scary that might happen. Stress is part of everyday living and gives you energy to succeed and do well. Stress makes your body produce chemicals that "get you going" such as adrenalin (epinephrine). Many people like the feeling of tension and excitement that they bring.

Some people believe that being always stressed and busy makes them more important, but it also means that you don't have much time for relationships with others. The chemicals that the body makes when stressed, are there to help a person fight what is stressing them or to run away from it. When a person does not use the chemicals to do this sort of physical work, the chemicals can cause some harm to the body. This is one of

the reasons why doing exercise when you feel stressed can make you feel less stressed (Miller, 1998).

2.8.2.3 THE ENGINEERING STRESS MODEL

Warren Smith, a metallurgist, in 1987, wrote an article entitled, "The Stress Analogy" in which he comments that Selye borrowed the term stress from engineers, but neglected to take along its definition. Smith states that it was the collapse of a bridge over a river on Interstate 95 in Connecticut in 1984 that first drew his attention to the engineering stress model (Kaplan, 1996). The main span of the bridge collapsed in the night without the slightest provocation by an "event" – no high winds, no unusual rate of traffic on that day, nothing. Basically, the continual stress to the bridge of unobserved rusting had simply reached a critical structural limit and the bridge collapsed.

In the engineering model, stress is essentially, an external force acting against a resisting body that may or may not operate within normative limits. Thus, one can say that stress also becomes a stressor when the level of force exceeds limits defining structural integrity. It appears at first glance that stressors and stress are not distinct phases in the engineering model; they both refer to the external force, pressure, threat to the body. This immediately makes this model more amenable to translation into the psychosocial model, and it provides some direction in defining what stressors are (Kaplan, 1996).

In the engineering model, stress is defined as the load exerted by a force divided by the capacity of the material to resist (Smith, 1987 in Kaplan, 1996). The engineering model also offers a clarification between the concepts stress and strain. Strain is the response state of the material, technically, the state of the elongation and compression of the material. Obviously, strain is the distress side of the model. The model refers to stress as occurring below or above normative limits, technically, within or beyond the "elastic limit" of the material. The elastic limit is an important concept, since it refers to the strength of the material in resisting stress forces. Coping capacity, in effect, defines the current elastic limit, which is dynamic.

The engineering model offers greater flexibility than when compared to Selye's biological stress model. The reason is that it allows for enhancement in coping capacity as a result of facing stressful situations, rather than just the minimization of damage to existing capacity. Even in the resistance phase of Selye's GAS, the best that is achieved is a return to prior levels of functioning. In the engineering model, the material, or the person, ends up with increased strength (Smith, 1987, in Kaplan, 1996).

2.8.3 WHAT CAUSES STRESS?

The potential causes of stress are numerous. One's stress may be linked to outside factors such as the state of the world, the environment in which one lives or works, or one's family. Stress can also come from irresponsible behaviour, negative attitudes and feelings, or unrealistic expectations (Frey, 2003). Furthermore, the causes of stress are

highly individual and includes factors such as: personality, general outlook on life, problem solving abilities and social support systems. Stressors can be divided into three broad categories (Dunn, 1997):

- **Frustrations** – Frustrations are obstacles that prevent one from meeting his or her needs or from achieving personal goals. They can be external – such as discrimination, an unsatisfying job, divorce, or the death of a loved one. Examples of internal frustrations include: physical handicaps, the lack of a desired ability or trait, and other real or perceived personal limitations.

- **Conflicts** – Stressors involving two or more incompatible needs or goals are known as conflicts. For example, a working mother might feel torn over a job offer that would advance her career, but take time away from her family. Sometimes, the conflict involves a choice between two desirable options.

- **Pressures** – Stress can stem from the expectations of others or the demands you place on yourself. You may feel pressure to excel at work, make a difference in the community, or be the perfect parent.

Stress becomes a problem when, instead of helping a person to do better, it causes him to do less well, or causes health or relationship problems. Stress can be harmful if something is happening that is too big for the person to manage, or if there are too many things happening, all causing smaller stresses at once. Sometimes stress problems can

"creep up on you" so you are not really aware of too much stress until things start going wrong (Canaff, 2004).

2.8.4 SIGNS AND SYMPTOMS OF STRESS

Stress affects the mind, body, and behaviour in many ways. The specific signs and symptoms of stress vary from person to person, but all have the potential to harm one's health, emotional well-being and relationships with others. What follows is a partial list of stress signs and symptoms that a person undergoing stress might experience (Miller, 1998):

Intellectual Symptoms: How stress can affect your mind

- Memory problems
- Difficulty making decisions
- Inability to concentrate
- Confusion
- Seeing only the negative
- Repetitive or racing thoughts
- Poor judgement
- Loss of objectivity
- Desire to escape or runaway

Emotional Symptoms: How stress can make you feel

- Moody and hypersensitive

- Restlessness and anxiety

- Depression

- Anger and resentment

- Easily irritated and "on the edge"

- Sense of being overwhelmed

- Lack of confidence

- Apathy

- Urge to laugh or cry at inappropriate times

Physical Symptoms: How stress can affect your body

- Headaches

- Digestive problems

- Muscle tension and pain

- Sleep disturbances

- Fatigue

- Chest pain, irregular heartbeat

- High blood pressure

- Weight gain or loss

- Asthma or shortness of breath

- Skin problems

- Decreased sex drive

Behavioural Symptoms: How stress can affect your behaviour

- Eating more or less

- Sleeping too much or too little

- Isolating yourself from others

- Neglecting your responsibilities

- Increasing alcohol and drug use

- Nervous habits (e.g. nail biting, pacing)

- Teeth grinding or jaw clenching

- Overdoing activities (e.g. exercising, shopping)

- Losing your temper

- Overreacting to unexpected problems

2.8.5 THE BUFFERS OF SOCIAL SUPPORT AND COPING IN REDUCING AND PREVENTING STRESS

There is an abundance of research that has shown that people with social support are less vulnerable to stressors than those without social support (Mirowsky & Ross, 1989; Pearlin & McCall, 1990). They all have in common ties of one sort or another to other persons (e.g. being married, having close friends, being involved in various networks). Support operates primarily by restoring or strengthening the normal self-verification processes that have been interrupted. Five different mechanisms are discussed by Pearlin and McCall (1990). The first is that support by one person shapes the meanings that the distressed person has been trying to control when the identity process was interrupted. In so doing, the supporting person helps the distressed person achieve congruence between the identity implications of the stressful situation and the identity standard of the distressed person. The second mechanism is related to this because it also involves the joint manipulation of meanings to re-establish some form of self-verification for the distressed person. Being let go from one job becomes an opportunity to find a better job.

The third mechanism is one of expanding the possibilities of control of the situation to re-achieve congruence. If the identity interruption occurs because the person can find no action alternatives that bring identity-relevant inputs back into congruence with their identity standard, then the supporting person may help find an action alternative that had not been considered. The fourth mechanism is directly relevant to the self-concept. What Pearlin and McCall suggest is that self-esteem suffers when a person faces stressful problems and that the supportive person may restore the loss of self-esteem in the distressed person by re-interpreting problems. The restoration of self-esteem by direct means ("you're great, you're smart, you can do that") and by affection and contact has

the effect of re-establishing self-verification. The fifth mechanism of support that Pearlin and McCall discuss is that of protecting the distressed person from other stressors while the current situation is being dealt with, and to divert the attention of the distressed person away from the immediate problem.

The second most mentioned buffer from the effects of stress is coping, which is often viewed as a resource (Pearlin et al., 1981). Distinctions are often made among coping responses according to the function of that response to: (1) modify the situation giving rise to the stressful problem; (2) modify the meaning of the problem to reduce the threat; and (3) manage the symptoms of distress. These are among the functions that support provides. Hence, whether a person accomplishes these functions on his or her own (coping) or with the help of others (support), it is the functions that are important.

2.8.6 THE DIFFERENT TYPES OF STRESS

There are several different types of stress, such as: acute stress, episodic stress, traumatic stress and chronic stress. This study relates to parental stress which falls under chronic stress and therefore a brief description of chronic stress is warranted at this stage. Chronic stress has been described as "unrelenting demands and pressures for seemingly interminable periods of time" (American Psychological Association, 1994). Chronic stress is stress that wears you down day after day, year after year, with no visible escape. It grinds away at both mental and physical health, leading to breakdown and even death (Webster-Stratton, 1990). Common causes of chronic stress include:

- Poverty and financial worries

- Long-term unemployment

- Dysfunctional family relationships

- Caring for a chronically ill family member

- Feeling trapped in unhealthy relationships or career choices

- Living in an area besieged by war or violence

- Bullying or harassment

- Perfectionism

One of the most dangerous aspects of chronic stress is that people who suffer from it get used to it. They accept chronic stress as their lot in life, or they forget it's there. Because chronic stress is based on long-term, often intractable situations, both the mental and physical symptoms of chronic stress can be difficult to treat (Webster-Stratton, 1990).

2.9 PARENTAL STRESS

The idea that children can cause stress in parents is an often exploited scenario in cartoon pages. "Dennis the Menace" has tormented his parents and other adults for decades, and Calvin, the little boy in the cartoon series "Calvin and Hobbes," kept a record on his calendar of how often he drove his mother crazy. Similarly, in the non-cartoon world, the question of whether children cause stress yields numerous raised hands in any group of parents. Indeed, a considerable number of publications in the psychological literature

supports the argument that children are a major source of stress for their parents (Crnic and Acevedo, 1995).

Rearing happy, well-adjusted children is quite an accomplishment for any parent. Knowing that you are effective with your children and can meet their needs contributes to parents' feelings of satisfaction. Hard work, responsibility, demands for time and attention are also part of parenting. This is the part of parenting that causes stress to mount and makes us feel caught and sometimes overwhelmed by demands constantly made upon us. The demands of a child are especially strenuous on new parents. New parents feel particularly worried and unsure. Most jobs require a training period to acquaint you with the new job responsibilities, but not the job of parenting (Pitzer, 2007). In addition to feeling inadequate about how to parent, mothers and fathers may sometimes be bothered by feelings of resentment. Taking care of children demands so much time and energy that it's not always possible to do some of the things that are important to you. Interruptions come at the most inconvenient times and no matter how ill or tired you feel, the children's needs must be met (Pitzer, 2007).

The interpersonal relations between parents and children have been the centre of intense interest for many decades. The characteristic mark of this interest is its concern with the effect that parents have on the development of children. However, the effect that children have on their parents' functioning and development has been largely ignored (Bell, 1968). For those of us primarily concerned with the social stresses experienced by adult members of the society, the impact of children on the lives of their parents is of utmost

concern. It is not a simple matter to identify this impact, partly because the influences that children exert over their parents change considerably over the life course. When parents evaluate their children as being on a trajectory that deviates from cherished goals, there is likely to be considerable strain, even if the children are independent adults. Parents don't easily become accustomed to what they consider to be their children's failures (Pearlin, 1980).

Because roles are usually embedded in role sets, the potential for conflict among those sharing the role set is considerable. Indeed, many of the frustrations and problems of people have been traced directly and proximately to their encounters and confrontations with others sharing the same role sets. This is nowhere more clear than in marriage and the relationship between parents and children (Kaplan, 1983). Aside from the problems that women encounter on the job, they are undoubtedly more exposed than men to conflicts between demands of the job, on the one hand, and demands of their housework, their marital roles, and their parental roles on the other. Research indicates that the more the job is in conflict with these familial roles, the more likely women are to be depressed (Pearlin, 1975a). Stress is part of parenting. Parents can be overwhelmed by the responsibilities of caring for their children and balancing work and the family, and can feel they do not have enough support.

Population studies have found that coercive or inconsistent styles of parenting are linked to higher rates of mental health problems in children (Silburn, Zubrick, Garton, Gurrin, Shepherd, & Lawrence, 1996). Research has shown that prevention and early intervention

strategies targeting parenting are amongst the most effective strategies for preventing

chronic problems (Webster-Stratton, 1997). Parenting stress is generally assumed to arise

from characteristics of the parent, the child, and the environment and interactions among

these factors (Abidin, 1992, 1995; Fischer, 1990; Mash & Johnston, 1990; Webster-

Stratton, 1990)

2.9.1 PARENTAL STRESS WITH SPECIAL NEEDS CHILDREN

All families experience normative and transitional life event stressors such as birth, death,

and moving. In addition, parents are subjected to the inherent chronic stressors of

parenting. Parental psychological stressors are related to the worries that parents have

about the physical safety and the growth and development of their children. Parents

generally take pride in their children's accomplishments and are hurt by their children's

failures. Parenting is particularly difficult and stressful when children do not measure up

to family or community expectations. When a child is diagnosed with a learning

disability, all of the attention is focused on helping the child and other family members'

feelings and frustrations are overlooked (Latson, 1995). Parents of special needs children

often find themselves trying to burn the candle at both ends. It seems the stresses and

strains they endure on a daily basis go far and beyond what they would believe

themselves able to cope with. Often they feel like an elastic band which has been

stretched beyond breaking point (Miller, 1998). Parents also need assistance in coping

with their own feelings and frustrations.

Families of those with learning disabilities, cognitive difficulties, brain injury and Autistic spectrum disorders seem to encounter more stress than others. This often comes from having different family dynamics, but it also comes in the form of social stress. Symptoms of any disorder can upset the entire family, which can turn the home, typically a secure and comfortable place, into a cycle of frustration and stress (Johnston, 1996).

In a study by Sherry, R. Latson (1995) investigating stress associated with parenting a child with learning disabilities, the results revealed that parents of children with learning disabilities perceived far more stress in their role as parents than did parents of children without learning problems. Some of the most frequently mentioned stressors these parents associated with raising their children with learning disabilities were:

- parent guilt

- worry about the future

- parents' perception that other people think they might be the cause of the problem

- difficult behaviour of children with learning disabilities

- feeling a need to protect their child

- disagreement between parents about the existence of a problem

- increased financial burden

- finding competent professional services

- sibling resentment of attention given to the child with learning disabilities

Parental stress can be grouped according to three categories: internal stress, external stress and physiological stress (Latson, 1996).

INTERNAL PARENTAL STRESS

Internal stress factors come from within the individual and include attitudes, perceptions, assumptions, and expectations. Expectations of parents about their child lie at the root of burnout. When expectations about parenting are not met, the first thought is "What did I do wrong?" Therefore, parents must learn how to develop realistic expectations and how to recognise when negative self-talk defeats effective coping. Parents should identify their own self-defeating assumptions and think of alternative messages. They must be kind to themselves, to accept themselves and their child as fallible, and to boost their own self-confidence by noting and using personal strengths and talents (Latson, 1996).

The following beliefs lead to internal stress (Latson, 1996):

1. Giving 100% every day is what every parent is expected to do.

2. The success or failure of my children depends entirely on me.

3. I will never be bored as a parent.

4. I will be seen by society as a good and honourable person because of the effort I put into being a good parent.

5. I refuse to let anyone else care for or influence my children.

6. I should always deny my own needs for rest and recreation in order to help my children.

7. I should do everything for my children and not require that they take on the responsibilities when they are old enough to do so.

8. I should spend every possible moment with my children.

9. I should feel guilty if I need a break or want some attention for myself.

10. One role in my life can satisfy all my needs and can support all my dreams.

11. My children should appreciate everything I do for them.

12. My children must like me.

13. Other people must see me as a good parent, able to handle everything.

EXTERNAL PARENTAL STRESS

External forces also impinge upon parents of youngsters with learning disabilities. Neighbours, friends, and relatives don't understand why such a normal-acting child is having academic problems. Teachers frequently don't fully understand the ramifications of the child's problems. Parents are called upon by the school to help make decisions about the child's academic programme but often feel helpless as the child's advocate because of their own lack of understanding. Because external stressors are those that are situational, and often involve relationships with others, parents are encouraged to develop assertiveness skills. Problem-solving techniques, time management, and goal setting are helpful when dealing with stressors associated with raising children and running a household. Because coping with a child with learning disabilities is so emotionally draining, parents also are encouraged to develop intimacy skills and a support system.

External stress factors include the following:

1. Dealing with school about child's placement or programme.

2. Coping with difficult child behaviours.

3. Educating neighbours and relatives about the child's problems.

4. Helping siblings understand the problems associated with learning disabilities.

5. Getting the child in the right school.

6. Helping the child with homework.

7. Financial pressures.

8. Working with the spouse on child management.

9. Carpools.

PHYSIOLOGICAL PARENTAL STRESS

The final type of parental stress is physiological stress. Parents of children with learning disabilities need to recognize that children with learning disabilities require exceptional amounts of energy. In order to replenish energy, parents need to be sure they get sufficient rest, eat well- balanced meals, and exercise vigorously. Parents need to learn meditation or relaxation techniques to use when they feel stressed, anxious, or fatigued. The following physiological stressors are commonly found in parents of children with special needs:

1. Diet

2. Exercise

3. Rest

4. Recreation

Parenting children with special needs presents special challenges. Professionals working with parents needs to recognize the difficulty parents face when dealing not only with the child's every day problems but also the associated social and emotional problems of school failure. According to the results of the study conducted by Latson (1995), parents are eager to learn better coping strategies and parent groups can provide both skill training and emotional support for parents of children with learning disabilities.

2.9.2 PARENTAL STRESS WITH ADHD CHILDREN

Raising a child with ADHD can have a significant impact on the functioning of families (Anastopoulos, 1998). Parents of children with behaviour problems, particularly children with ADHD, experience highly elevated levels of daily child-rearing stresses (Abidin, 1990) and are found to have a diminished sense of parenting competence (Mash & Johnston, 1990). Numerous studies have established that parents of ADHD children experience a higher degree of parenting stress than parents of children without a behaviour disorder (Wells, Epstein, Hinshaw, Conners, Klaric, Abikoff, Abramowitz, Arnold, Elliot, Greenhill, Hechtman, Hoza, Jenson, March, Pelham, Pfiffner, Severe, Swanson, Vitiello, & Wigal, 2000).

Children with ADHD disregard parental requests, commands, and rules; fight with siblings; disturb neighbours; and have frequent negative encounters with school teachers. Children with ADHD have problems paying attention, controlling impulses, and modulating their activity level (Pelham & Lang, 1999). They are more talkative, negative

and defiant; less compliant and co-operative; sustain their compliance for shorter time periods; are less likely to remain in task; are more demanding of assistance from others; and are less able to play and work independently of their mothers (Barkley, 1985; Danforth, Barkley & Stokes, 1991; Gomez & Sanson, 1994; Mash & Johnston, 1982).

In families of children with ADHD the characteristics of the child are thought to be the primary contributor to parenting and family stress (Anastopoulos, Guevremont, Shelton, & DuPaul, 1992). Research finds that ADHD affects the interactions of children with their parents and, hence, the manner in which parents may respond to these children. In what Johnston (1996) labelled a "negative-reactive" response pattern, parents of ADHD children display more directive and commanding behaviour, more disapproval, fewer rewards, and more overall negative behaviour than the parents of normal children do (Barkley, Karlsson, & Pollard, 1985; Befera & Barkley, 1984; Cunningham & Barkley, 1979; Mash & Johnston, 1982; Tallmadge & Barkley, 1983).

The disturbed and conflictual nature of parent-child interactions in families with a child who has ADHD has been demonstrated in several research studies. Children with ADHD are less compliant to their parents' instructions, sustain their compliance for shorter time periods, are less likely to remain on task, and display more negative behaviours than their normal, same-age counterparts do (Wells, 2000).

Parenting stress and a negative family environment are unpleasant in their own right, but outcome studies have shown more serious effects. Studies with ADHD adolescents and

their parents show continuation of elevated levels of negative interactions, angry conflicts, and less positive and facilitative behaviour towards each other, relative to normal adolescents and their families (Wells, 2000). In addition to disrupted parent-child interactions, the family life of children and adolescents with ADHD is often characterised by discord and disharmony (Baldwin, Brown, & Milan, 1995 in Wells, 2000). Increased rates of maternal depression, as well as marital conflict, separation, and divorce have also been noted. Some of these associations may reflect genetically linked disorders in parents and offsprings. They may also reflect personal, emotional, and marital responses to the high rates of aversive behaviour displayed by the child with ADHD; high rates of negative parent-child interaction, and care giver burden associated with being the parent(s) of a child with ADHD (Wells, 2000).

These previous findings imply that decreases in negative parent-child interactions, as well as parenting stress, maternal depression, and conflict between the marital/parenting dyad are important secondary outcomes of treatment of the child with ADHD and his family. These facets of family life, singly and collectively, are difficult and unpleasant in their own right. Negative parent-child interactions are of etiological significance in disruptive behaviour disorders and predict greater non-compliance in classroom and play situations as well as greater covert stealing (Pelham & Lang, 1999). ADHD children raised in an environment characterized by negative parent-child interactions and family dysfunction have an increased risk for later substance abuse, criminality, and antisocial disorders (Hechtman, 1996; Klein & Mannuzza, 1991).

It is also linked to disruptions in parent psychological functioning, including depression, negative attributional style, and reduced parenting efficacy, that hinder parental perceptions of child behaviour and can lead to more punitive and less responsive parenting (Belsky, 1984; Mash & Johnston, 1990; Rodgers, 1998). Children with behaviour problems, particularly those with such externalizing disorders as ADHD, can adversely affect their parents' mental health (Mash & Johnston, 1990). Childhood externalizing problems frequently result in stressful family environments and life events affecting all family members, including parents. For example, numerous investigators have reported higher rates of current depression in mothers of children who were referred to a clinic because of behavioural problems than in mothers of healthy children (Fergusson, Lynskey, & Horwood, 1993).

In addition, a significant correlation exists between daily parenting hassles (e.g. experiencing difficulty finding a baby sitter, having to talk to a child's teacher, or coping with fighting among siblings) and child behaviour problems. Thus, studies investigating the distressing effects of deviant child behaviour on the immediate reactions and long-term functioning of parents have shown that exposure to difficult children is associated with dysfunctional parental responses (Pelham & Lang, 1999).

In a study by Pelham and Lang (1999) on the influences of child behaviour on parental drinking, it was concluded that after interacting with the deviant children, the mothers of ADHD children showed greater physiological distress (that is, significantly increased heart rate and blood pressure) than after interacting with the normal children. These

mothers also showed greater subjective distress (that is, increased negative affect; decreased positive affect; and increased self-ratings of unpleasantness, unsuccessfulness, and ineffectiveness. Furthermore, the mothers consumed approximately 20% more alcohol after interacting with the deviant children than after interacting with the normal children (Pelham & Lang, 1999).

Summarizing across the research on families of ADHD children it has generally been found that parent-child difficulties have been observed. Mothers of ADHD children reported less parenting self-esteem and more stress than mothers of normal children. Increased levels of depression, psychiatric disorders, substance abuse, family adversity, marital dissatisfaction, parenting stress and criminal activities have also been found in families of ADHD children (Johnston, 1996). Interestingly, ADHD children appear to be more compliant and less disruptive with their fathers than their mothers (Tallmadge & Barkley, 1983). According to Tallmadge and Barkley, there are several possible reasons for this. For one, mothers are still the primary custodians of children within the family, even when they are employed outside the home, and may, therefore, be the ones who are most likely to tax or exceed the child's limitations in the areas of persistence of attention, activity regulation, impulse control, and rule-governed behaviour. Another reason may be that mothers and fathers tend to respond to inappropriate child behaviour somewhat differently.

In a study examining the social and psychological functioning of biological parents of ADHD children (Murphy & Barkley, 1996), it was found that these parents had inherent

impairments or deficiencies themselves, such as: lower self-esteem, higher levels of depression, self-blame, and social isolation; marital disturbances; antisocial behaviour; alcoholism; hysteria or affective disorder; or learning disabilities. Decreased extended family contacts are also noted in families with ADHD children (Cunningham, Bennes, & Siegel, 1988). Parents may feel blamed for their children's behaviour by extended family members. Conflicting understandings of ADHD and its treatment may further isolate parents from their families, who might otherwise be a source of support (Alexander-Roberts, 1995).

Often complicating the problems associated with ADHD is the presence of a comorbid Oppositional Defiant Disorder (ODD). The core symptoms of ODD include angry, vindictive, argumentative, and defiant behaviours (American Psychiatric Association, 1994). Fifty percent of ADHD children referred to clinics are diagnosed with ODD (Greenhill, 1998). The presence of comorbid ODD has also been shown to be associated with greater maternal stress and psychopathology as well as marital difficulties (Barkley, Anastopoulos, Guevremont, & Fletcher, 1992; Barkley, Fischer, Edelbrock, & Smallish, 1991).

2.9.3 FACTORS ASSOCIATED WITH THE PSYCHOLOGICAL STRESS EXPERIENCED BY PARENTS WITH ADHD CHILDREN

The severity of a child's symptoms would be one important factor, with more severe symptoms linked to greater parental stress. Several researchers have suggested, however,

that how parents interpret their child's behaviour, and whether they believe they have control over their child's behaviour, are also important factors to consider (Harrison & Sofrofoff, 2002). Researchers have suggested that parents who consistently regard the behaviour problems of their ADHD child as under their child's control, as opposed to recognizing how ADHD often contributes to non-compliance, are prone to feelings of anger and discouragement. Some researchers have speculated that when this occurs, parents can withdraw from their child in an attempt to avoid further failure which they view as reflecting their own incompetence as parents.

The relationship between parents' attributions and beliefs about the controllability of children's behaviour, and parents' psychological distress was recently examined in a study by Harrison & Sofrofoff (2002). The results from this study suggest that children's behaviour problems, and mothers' beliefs about being able to control their child's behaviour, contribute to parenting stress and depression in mothers of children with ADHD. Not surprisingly, mothers whose children displayed greater behaviour problems reported higher levels of stress and depression.

What is noteworthy, however, is that maternal distress was more strongly predicted by overall child behaviour problems than by the severity of ADHD symptoms specifically, that predicted maternal distress. This suggests that when other behavioural and emotional problems do not accompany children's ADHD symptoms, the impact on mothers' psychological well-being will be diminished. Thus, preventing emotional and behavioural

problems from developing in children with ADHD may not only result in better outcomes for children, but for their mothers as well.

Given the theories on the causes of ADHD (genetic) and the theories on parental stress, can one really find the results of these studies surprising? Some call the times we live in "the age of anxiety". Fractured marriages, disconnected families and harried parents make stress an everyday occurrence to many of our children. The significant impairment experienced by children with ADHD, combined with the links between elevated parenting stress, disruptions to the parent-child relationship, and parenting practices argue for treatment programmes that reduce parenting stress in the families of children with ADHD.

2.10 THEORETICAL FRAMEWORK

Given that parenting stress is generally understood to arise from characteristics of the parent, the child, and the environment, and interactions among these factors and for families with a child with ADHD, the characteristics of the child are thought to be the primary contributor to parenting and family stress (Anastopoulos et al., 1992; Mash & Johnston, 1983; Fischer, 1990; Johnston & Mash, 2001), then it is only fitting to use a family systems model to explain the nature of negative interactions between children with ADHD and their parents within the family sub-system which give rise to parental stress.

Our staring point would have to be a brief review on the conceptions of the family, the various different schools of family systems theory will be discussed, thereafter, the reciprocal interaction model of stress and Hill's family stress theory will be visited before explaining how the stressful interactions between parents and their ADHD children occur in a mutually reinforcing cycle (Lehrer & Woolfolk, 1993).

2.10.1 THEORIES ON THE FAMILY

Theories of child development, which approach the family from the child perspective, include concerns with nature versus nurture, the flexibility or plasticity of the child at different ages to being moulded by the family, and the relative permanence of family influences (Kreppner & Lerner, 1989). Exploration of family effects often is reduced to the examination of dyadic parent-child interactions, usually focusing on the mother-child dyad, with little attention to family dynamics.

Perspectives on the family both, as an entity and as a producer of developmental outcomes of its members (Kreppner & Lerner, 1989) depict it as a social context or "climate" facilitating the individual's entry into other social contexts and as an environmental factor containing both, genetically shared and non-shared components for the developing individual. The family is seen as a dynamic context in which the child is both, the transformer and the transformed.

2.10.1.1 The Bronfenbrenner Model

Bronfenbrenner (1979) placed child development in an ecological perspective. The relationships between individuals and their environments are viewed as "mutually shaping". He saw the individual's experience "as a set of nested structures, each inside the next, like a set of Russian dolls" (Bronfenbrenner, 1979). His four interlocking systems are:

1. The micro-system – At this level the family enters Bronfenbrenner's framework, but only in terms of its interpersonal interactions with the child. It is a level within which a child experiences immediate interactions with other people. At the beginning, the micro-system is the home, involving interactions with only one or two people in the family (dyadic or triadic interaction).

2. The meso-system – These are the inter-relationships among settings (e.g. the home, a day-care centre, and the schools). The quality of a child's meso-system is dependent on the initiatives of the child and the parents' involvement in linking the home and school.

3. The exo-system – the quality of inter-relationships among settings is influenced by forces in which the child does not participate, but which have a direct bearing on parents and other adults who interact with the child. These may include the parental workplace, school boards, social services agencies, and planning commissions.

4. The macro-system – These are the "blueprints" for interlocking social forces at the macro-level and their inter-relationships in shaping human development.

2.10.1.2 The Belsky Process Model

Belsky (1984) pioneered theories of the processes of competent parental functioning. His model focused on factors affecting parental behaviour and how such factors affect child-rearing, which in turn influences child development. At the family level, Belsky's interest was primarily on interpersonal interactions between parent and child. Belsky (1984) states "The model presumes that parenting is directly influenced by forces emanating from within the individual parent (personality), within the individual child (child characteristics of individuality), and from the broader social context in which the parent-child relationship is embedded."

Belsky (1984) drew the following conclusions regarding the determinants of parenting:

1. Parenting is multiply determined by characteristics of the parent, of the child, and of the contextual subsystems of social support;

2. These three determinants are not equally influential in supporting or undermining parenting; and

3. Developmental history and personality shape parenting indirectly, by first influencing the broader context in which parent-child relations exist (such as marital relations, social networks, occupational experience).

Belsky found that parental personality and psychological wellbeing were the most influential of the determinants in supporting parental functioning. The influence of

contextual subsystems of social support is greater than the influence of child characteristics on parental functioning (Caldwell & Bradley, 1984).

2.10.1.3 The Schneewind Model

Schneewind (1989) provides a psychological model of the family and its effects on children. Schneewind called this model "an integrative research model for studying the family system." Using this model, Schneewind tried to understand how and to what extent the "extra-familial world" is associated with the "intra-familial world" in the processes of socialization within the family.

Socio-economic and demographic variables are used as contextual variables reflecting the spatial and social organization and social inequality. These variables represent the family's eco-context for further use. This eco-context is a potential source of stimulating agents that can be used by parents in performing their parental functioning. The process of transforming the potential source into the actual experience field of both, parents and children is called the "inner-family socialization activity" (Schneewind, 1989).

The inner-family socialization activity is divided into three parts:

1. The family system level, or the family climate that measures the overall quality of interpersonal relationships within the family;

2. The spouse subsystem level, or the marital relationship;

3. The parent-child subsystem level, or the educational style indicated by parental behaviours and attitudes or authoritarianism.

Schneewind (1989) concluded that "the psychological make-up of family life...has an important influence on how a family's potential eco-context is actually utilized." This is similar to Belsky's conclusion that personality and the psychological well-being of parents have the greatest influence on parental functioning.

2.10.2 FAMILY SYSTEMS THEORY

The social-relations orientation to psychological counselling and therapy, unlike other orientations, has its principle focus on systems. A systems approach asserts the group and the family as its basis, rather than only the individual. From a systems perspective, there are various approaches to family therapy, namely: the Psychodynamic, Structuralist and Strategic approaches. These are not the only approaches that have made an impact on family therapy research, but they are appropriate for the purposes of this research study.

In terms of systems thinking, each family is a totality, that is, it is more than the sum of its parts. But it is also made up of smaller parts or subsystems of which the individual is the smallest. These subsystems might include the sibling, parental or spousal subsystems. With the emphasis on relationships, neither the individual nor the environment can be ignored. The family is a complex network of relationships and emotions that cannot be studied using the instruments designed for the isolated study of individuals (Relvas, 1997). Within the family, all members are reciprocally tied to all other family members.

Family therapists tend to adopt systems theory for their own because of its usefulness in describing human interactions (Becvar & Becvar, 1996). Systems theory is less of a theory and more of a way of thinking. Auerswald, (1985) refers to a new way of 'thinking about thinking' or a new epistemology. This, he suggests, is a new set of rules governing thought. This is profoundly different from the predominant thought system of the Western world. The so-called Newtonian world-view is inappropriate for explaining social relations as it is bound by linear notions of causality. Keeney (1979), states that the medical model of psychopathology is based on this outdated way of thinking as it is depicted as atomistic, reductionistic and anti-contextual. Systemic epistemology, on the other hand, is based on inter-relationships, complexity and context. Systems theory emphasizes circularity of effects as each part influences and is mutually influenced by other parts within the system (Becvar & Becvar, 1996). In this way, systems thinking could be referred to as a meta-theory, because of its all-encompassing nature.

The idea is that if a member in a family unit makes any major changes in behaviour, others in the family will behave in ways to prevent the change from happening. This reaction is most likely due to fear of change at subconscious levels (Kanel, 2003). Change often makes people feel anxious. Counteractive behaviours are used to lessen anxiety, often without family members realizing what they are doing. Therapists point out these processes and make clients conscious of what they are doing. Typical counteractive behaviours used by family members include shaming the target member, threatening the person, and excluding or punishing the person. Family systems theory helps explain why dysfunction exists in families so regularly and why change takes a long time to occur.

Runaways

Runaway is the term used in the family systems model to describe a true family crisis. A runaway exists when the counteractive/negative feedback mechanisms fail to bring the situation back into calibration, that is, family members cannot create homeostasis by normal coping mechanisms (Kanel, 2003). This runaway state often triggers a family to seek family counselling.

Of course family therapy models have usually focused on providing brief interventions. Reframing and assigning positive connotations are two major intervention strategies in family systems approaches, particularly the strategic models. Both these techniques aim at changing the internal cognitive experience of family members.

2.10.2.1 FAMILY THERAPY

The term Family Therapy could more appropriately be called Relationship Therapy. Both are built on the assumption of systems theory. This theory describes relationships and patterns of interactions within a social arena. Since it is the family that has the greatest impact on our everyday existence, this is the context in which family therapists operate and give most of their attention.

Broadly, family therapy brings together members of the same family, the assumption being that a person experiencing problems related to family life cannot be treated apart from the family (Sdorow, 1993). Family therapy tries to improve communication

between members who learn to give and receive feedback from each other. An atmosphere is created so that no individual is blamed for the family's problems.

2.10.2.2 THE PSYCHO-DYNAMIC APPROACH

Becvar and Becvar (1996) suggest that psycho-dynamic approaches to family therapy be termed transgenerational and thus not strictly systemic in nature. They focus on changing the individual and thereby effecting a dynamic shift in family patterns. Their basic assumptions are firstly that emotional illness is developed in relationships with others and secondly, that the relationship between client and therapist is the best treatment for emotional illness. There is however a paradox in speaking about psychoanalytic family therapy. Psychoanalysis focuses on the intra-psychic domain whilst family therapy stresses relationships. The difference is that psychoanalysis places emphasis on the internal world, whereas family therapy places greater emphasis on the external world.

Theorists operating from this perspective generally follow the traditions of psychoanalysis, yet assume that problems in relationships existing within the client's current family life requires intra-psychic exploration and the resolution of unconscious object-relations resulting from early parent-child relationships. The differentiation of the individual is the catalyst for change and progresses towards the transformation of relationships within the entire system. One of the best known proponents of the psychodynamic approach to family therapy is Murray Bowen (Becvar & Becvar, 1996).

2.10.2.3 THE STRUCTURALIST APPROACH

Like other family therapies, the structural approach considers the patterns, processes and transactions that occur within the family system. The structure of the family refers to the way in which it is organized. A family operates through repeated transactional patterns that become fairly persistent and these patterns serve to regulate the behaviour of family members. They therefore provide a set of rules for behaviour, of which the individuals are rarely aware (Becvar & Becvar, 1996). All families develop some form of hierarchy, usually with the parents in the position of greatest authority.

Structural family therapy attempts to help everyone in the family move through new developmental stages at the same time by learning new roles in the family that are more adaptive. The range for allowable behaviours will be re-calibrated with the effect of reducing counteractions (resistance). New boundaries are established that allow for age-appropriate independence and nurturance (Kanel, 2003). Minuchin (1974) points out that these are the two main functions of a family: to provide support and nurturance and to create individuals who can function in society independent of their family of origin.

The main goal of therapy is structural change of the family. Therapy provides a concrete explanation of structures that lead to dysfunction and moves the family towards alternative structures of operation. Various systemic principles are adopted in this approach, namely, stability and change and openness and closeness. A delicate balance ensues between these ideas. The family must remain stable whilst at the same time,

undergoing appropriate structural change. Stability and change are two sides of the same coin. Change is inevitable and serves to maintain the family's survival and to maintain its stability (Relvas, 1997). Boundaries between subsystems must be both open and closed, in other words, a level of semi-permeability should be encouraged.

Certain terms may be helpful to identify healthy versus unhealthy structures in families. They also shed light on why certain problems exist in families. These are the words that describe boundaries that often need expansion or restriction (Kanel, 2003).

Enmeshed Families

In an enmeshed situation, everyone in the family interferes and is overly involved in everyone else's decisions, feelings, wishes, and behaviours. Children may know too much about their parents and vice versa. An enmeshed family is observed when one sees a lack of independence of thought and feeling among family members. These families typically see themselves as very close or too close. Children from enmeshed families often grow up to find themselves in unhealthy relationships where battering, alcoholism, and other forms of abuse exist. A child grows up feeling no sense of separateness and has problems making decisions and functioning in other adult situations. Depression and anxiety are common in relationships. A crisis state may occur when someone in the family attempts to break out of the enmeshment. Others may react by subtly punishing the individual, perhaps by the silent treatment or non-inclusion in family affairs.

Diffuse Families

A family is diffuse when members are not clear about who is to do what. Roles are not well defined or may be inconsistent (such as when a 16-year-old girl raises a baby in the same home with her own parents. The baby will be confused about the role of his mother as he watches her be parented while she parents him). A pathological variation of this is called cross-generational coalition; here a parent and child team up against the other parent, thereby crossing the parent/child boundary. Clear age-appropriate boundaries are essential to healthy emotional functioning.

Disengaged Families

In a disengaged family, distance is the pattern. The rule in these families is not to get too close emotionally or socially. The relationship between parents and children and between spouses tends to be more functional than in some other troubled families. Independence is encouraged. However, children may feel unsupported and unloved in families where disengagement is strong. This feeling could lead to gang involvement, substance abuse, or teen pregnancy as a way for children to seek love and support or not to feel anything (substance abuse). Intervention here is aimed at helping families learn how to show support to one another and to increase a sense of belonging.

Rigid Families

In families with rigid boundaries, spouses and children are treated only one way. There is no crossing over between generations: children are to be seen and not heard. Wives clean, husbands work. Children obey. Father disciplines. Mother takes care of children. These rules are typical and can lead to rigid personality structures in children who are brought up this way. Counsellors need considerable skill to be able to reframe and educate parents with rigid boundaries.

All families experience events over time that can lead to crisis situations. Examples are the birth of a child, sickness, death, divorce, an extra-marital affair, and children leaving home. Whether they are sudden or expected, they all provide a challenge for the family and therefore necessitate a change in family structure and a re-alignment of roles.

One of the principal proponents of the structural approach is Salvador Minuchin. Structural therapists believe in becoming part of the system they are treating and join the family within their home. The therapist ascertains the family's underlying structure and then attempts to transform the structure by suggesting alternatives (Becvar & Becvar, 1996). It is often the case that one member is designated the identified patient. The structural therapist may need to change this perception and to get the family to focus on relationships instead, to evolve an appropriate family structure to accommodate the individual pathology. Parents are always consulted first to re-affirm the parent/executive role, so important to Minuchin's 'ideal family' (Becvar & Becvar, 1996).

2.10.2.4 THE STRATEGIC APPROACH (MILAN SCHOOL)

In this model, the goal is to shift the rules in the family to bring about a new homeostasis that does not include pathological behaviours. A basic premise of strategic theorists is that people define their problems from their own particular perspective or framework. They therefore can only see possible solutions from that same framework and this limits the options. If a problem were to be reframed from another perspective, it would cease to be a problem. Reality is based on perception. Things are not the way they are, rather, they are what they are because they have been perceived and conceptualized as such (Becvar and Becvar, 1996). The aim of the strategic therapist is therefore to change people to view another perspective of the same situation. The family is not seen as pathological or dysfunctional, rather they are merely 'stuck' in terms of redundant patterns of interaction.

Reframing a developmental crisis as a family or marital problem or a simple matter of adjustment is a common intervention. In addition, prescribing the symptom is also a technique in alleviating crisis states (Haley, 1976). When using this technique, the counsellor suggests that the client or family members engage in the problematic behaviour but with a slight modification. For example, clients who are very depressed might be told that they are not letting themselves really feel depressed and that they should close all the windows and curtains and sit in the dark. They are to focus on their sad feelings and cry for one hour. This episode will allow the clients to experience their symptoms in a new way. Usually, it results in an alleviation of the symptoms. A

counsellor must take great care with this technique and be well trained or receive expert supervision in using it. It is not recommended for suicidal clients.

Short-term homeostatic systems therapy includes the following six stages (Kanel, 2003):

1. Introduction to treatment

2. Definition of the problem

3. Estimation of the behaviours maintaining the problem

4. Setting goals for treatment

5. Selecting and making interventions

6. Termination

Symptoms are seen as strategies to define the nature of a relationship. They serve an important function within the family and help to maintain the family. They are associated with complex reciprocal feedback mechanisms within systems (Becvar and Becvar, 1996). Typically, strategic therapists search for 'triads' of behaviour patterns.

These often contain both parents and a child. A child misbehaves, the father is usually inattentive but his intervention is heavy-handed, the mother compensates by over-nurturing the child, the father feels alienated and reverts to a peripheral role, the child wishes for the father's attention, the child misbehaves. This description appears to follow a linear sequence. Rather, it is illustrative of circularity, a pattern of behaviour that has no cause. The cycle has no beginning and no end, forming an interwoven network where all members are reciprocally tied to all other family members.

One team of researchers who have worked within the parameters of the strategic model is the Milan School, consisting of Selvini Palazzoli, Boscolo, Cecchin and Prata. The technique of 'circular questioning' is principally associated with the Milan School of Strategic Therapy. Circularity means 'the capacity of the therapist to conduct his investigation on the basis of feedback from the family in response to the information he solicits about relationships and, therefore, about difference and change' (Palazzoli, Boscolo, Cecchin, & Prata, 1980). Each member of the family is asked questions about how they perceive relationships. The therapist takes responsibility for what happens in the sessions, but takes no responsibility for change. This is totally up to the family.

2.11 MODELS OF FAMILY STRESS THEORY

Two models of stress theory will now be discussed, namely, the Reciprocal Interaction Model of Stress and Hill's ABCX Model of Family Stress as both of these models espouse a systems approach to stress and are relevant to the current study which is an evaluation of parents' experiences in a stress management programme for parents with ADHD children.

2.11.1 THE RECIPROCAL INTERACTION MODEL OF STRESS

Stressful interactions with other people occur in a mutually reinforcing cycle of maladaptive cognition reactions. Specific mechanisms, such as egocentric cognitive mode, framing and polarization, lead to increased mobilization and consequently to stress

(Lehrer & Woolfolk, 1993). Stress does not occur in a vacuum. When we look at the interpersonal relationships of stressed individuals, we realize that their behaviour evokes responses from other people, which are fed back to them and stimulate further responses in them. Ordinarily, interpersonal responses are modulated in such a way as to minimise the amount of friction among people, and also the degree of disturbance within individuals. Thus, people operate as though they have a kind of "thermostat" that regulates their behaviour. When these adjustments in behaviour do not occur in an adaptive way, the stage is set for stress in individuals and/or in the persons with whom they are interacting (Lehrer & Woolfolk, 1993).

Cognitive-Behavioural Interactions

Cognitive behavioral theory was first introduced by Beck, Rush, Shaw, and Emery and was subsequently expanded upon by numerous authors and researchers (for example, Burns, 1980; Ellis, 1962; Lewinsohn, 1974). This theory posits that affective states, behavior, and cognitive processes are interrelated. The theory focuses on the extent to which the valence, or style of an individual's cognitions, influences that individual's affective experience. For instance, if an individual selectively interprets his or her experiences in a negative manner, then there is likely to be a commensurate negative affective experience. Treatment methods include identifying specific types of cognitive distortions and replacing negative, maladaptive cognitions with healthier ones. The intent is to improve the individual's mood by identifying and replacing irrational and distorted cognitions and beliefs (Beck, Rush, Shaw, & Emery, 1979).

Cognitive restructuring has often been implemented in conjunction with other stress management interventions (Forman, 1990). Stress management interventions that include cognitive restructuring are more effective than those that do not (Bellarosa & Chen, 1997). Cognitive restructuring assumes that emotion has a cognitive component and that the modification of this component produces a change in behavior. The overarching theory behind such interventions is that an individual can change the valence of his or her thoughts by replacing irrational or negative beliefs with more adaptive and positive ones (Beck et al., 1979). This, in turn, is believed to result in a positive change in emotional state.

A more comprehensive reciprocal or interactional model demands the inclusion of cognitive structuring. Thus, an individual structures a particular situation with another person in a specific way. The individual's structuring of the situation will lead to a particular behaviour. His or her behaviour is interpreted in a specific way by the other person, who then manifests a behaviour response to this interpretation. Thus, we get a continuous cycling of cognition→ behaviour→ cognition→ behaviour (Lehrer & Woolfolk, 1993). It is this cycle that leads to stress.

The Egocentric Mode

When people consider their vital interests to be at stake, they are likely to shift into the egocentric mode (Lehrer & Woolfolk, 1993). The egocentric mode organises present, past, and future situations or events predominantly in terms of how they affect the

individual's own vital interests. Since such individuals are focused on the meanings of the events to them, the meanings of other persons are not part of their phenomenal field. In interpersonal relationships, clashes are likely to occur when each individual is operating solely within the egocentric mode. Even though the individual may have no desire to hurt, his or her egocentricity places a burden on the other person and ultimately on himself or herself. A clash is likely to occur because each person's construction of his or her own behaviour and of the other person's behaviour will inevitably lead to a conflict of interest.

Framing

When people view other people with whom they are in conflict, they tend to make an appraisal not only of the other's behaviour, but of the other persons themselves. Generally, the type of actions that people consider to be most typical of others, or most salient in terms of their interactions with them, are transformed into images or concepts of the other individuals (Lehrer & Woolfolk, 1993). Framing consists of focusing on some characteristic one attributes to another person and portraying this individual in such a way that this attribute dominates the picture of that person. The term "frame" is applied to the specific image or concept of an individual with whom one is in conflict. In creating a frame, one not only reduces a highly complex individual to a few negative character traits, but manufactures additional elements to flesh out the image.

Polarisation

Polarisation consists of two interacting phenomena: external polarization that is, moving further apart in their expressed opinions of each other and internal polarization, thinking more negatively of each other. Their view of each other becomes more and more negative until it is finally hardened into a specific frame (Lehrer & Wolfolk, 1993).

2.11.2 HILL'S ABCX MODEL OF FAMILY STRESS

According to Professor Reuben Hill, family stress theory sets forward acute stressors (meaning sudden onset) which when accumulated could lead to family crises, including physical, emotional, or relational crises (Mattessich & Hill, 1987). However, their impact can be muted, or buffered with protective factors which help families to survive multiple contextual stressors. These protective factors buffer the impact of the stressors, and one includes social relationships (B Factor) and the other includes perceptions (C Factor). Social relationships are further distinguished as being within family variables, e.g. attachment, positive family bonds, effective communication, as well as across family variables, that is, social isolation versus informal and formal social support networks; perceptions (C Factor) include the range in cognitions and attitudes between hope and personal effectiveness versus despair and helplessness. These two complex factors relate together with the acute stressors and ongoing social context of chronic stressors, to predict family crises.

Hill theorized that there are two complex variables which act to buffer the family from acute stressors and reduce the direct correlation between multiple stressors and family crises (Mattessich & Hill, 1987). According to his ABCX theory of family stress, the "A" variable refers to family stressors, the "B" variable refers to the complex internal and external family resources and social support available to the family, that is, the social connectedness within the family, as well as social connectedness outside the family. Hill theorized that social isolation would significantly increase the impact of the multiple stresses on the family functioning; in contrast, positive social supports would minimize the impact.

Hill's "C" variable, the perception factor, was the second predictor of the extensiveness of the impact of stress on the family (Mattessich & Hill, 1987). This second complex factor referred to the shared family cognition and perceptions held about the stressors, that is, the extent to which the family perceived the changes as a disaster versus an opportunity. Hill suggested that some families had positive appraisals which they could make of changes, which increased their ability to accept their circumstances. Finally, the "X" factor is the resulting family crisis.

Hill (Mattessich & Hill, 1987) stated that if a family experiences multiple stressors and (1) they are socially isolated and emotionally disconnected to one another, and (2) they are depressed, hopeless, and disempowered, then they will be at increased risk for illness, accidents, child abuse and neglect, and substance abuse, delinquency and school failure. With a positive set of cognitions, an empowered attitude, and an active informal and

formal support network, there would be a reduction in the likelihood that the stressful life experiences would result in a family crisis.

2.12 A SYSTEMS THEORY PERSPECTIVE OF THE INTERACTIONS WITHIN A FAMILY WITH AN ADHD CHILD

Studies have demonstrated that family dysfunction is common in families with ADHD children and that family members often suffer serious psychological effects (Shelton, 1998). When one family member is hurting, everyone feels the pain. Everyone reacts to the pain – parents, brothers, sisters, and grandparents. Everyone in the family needs to understand the behaviours resulting from ADHD and their reactions to these behaviours. It is not easy to live with a child or adolescent with ADHD. Their constant activity, noise, or getting up and down during meals is annoying. Their short attention span and difficulty staying on task when reading or doing activities is frustrating.

Their interrupting, calling out, and inappropriate or potentially dangerous behaviour is upsetting. Homework time is a struggle, if not a battle. Parents watch their son or daughter playing with others and see how different his or her behaviour is compared to the others'. Teachers complain about the child's class behaviour or the incompletion of tasks. Neighbours call to tell parents what he or she did. The other children are angry with their sibling and want their parents to "make him stop" or "tell her to be quiet". And since parents don't understand what's going on either, they get frustrated and angry. Worse, they feel helpless, not knowing what to do (Dunn, 1997).

All of these experiences will be made worse if each parent reacts to his or her frustration, confusion, and anger in a different way. One parent tries to be understanding and permissive, and the other insists on firmness and punishment. One parent tries to keep the peace, and the other withdraws, using work or some other excuse not to be home in the evening. When home, this parent often handles his or her helplessness by blaming the other parent for all of the problems. Rather than each parent supporting the other through this family crisis, each begins to clash with the other (Biederman, Milberger, Faraone, Kiely, Guite, & Mick, 1995).

The other children in the family have a rough time too. They react with frustration, anger and embarrassment when their friends are over and see the ADHD sibling acting out. They feel stressed and they want their parents to "fix the problem". Soon the whole family is dysfunctional. No one is happy. No one feels like being understanding and nice to the child or adolescent with ADHD (Kaplan, Crawford, Fisher, & Dewey, 1998). Parents' and siblings' ills will become so great that everyone forgets that the child or adolescent with ADHD is hurting too. He or she is the direct recipient of the looks and reactions of disappointment, disapproval, and anger. This child has only had one brain all his or her life and doesn't know that it is different. He or she is confused. Why do I always get into trouble? What is everyone so mad about? I didn't do anything! (Silver, 1999).

Often added to these stresses on each family member is the lack of help from others. Numerous complaints to the family doctor are met with "He'll outgrow it" or "You have

just got to relax." Grandparents remind parents that if they were more strict and firm, there would be no problems. Teachers make parents feel as if their son or daughter is "bad" and that they need to make him or her "better". Those looks from others in the grocery store or shopping mall communicate the same messages – the child is bad and the parent does not know how to parent (Silver, 1999).

It is normal for a parent to have difficulty fully accepting that their child is different. Often they experience a series of reactions not too different from the reaction of grief that people have when someone dear to them dies, although this grief is of a lesser intensity. If the initial feelings of denial, anger, or guilt are not resolved, a parent might move into a chronic state of experiencing these feelings and reactions (Kendall, 1998).

A parent in chronic denial may continue to "doctor shop" in a constant search for the doctor with the magic answer or magic cure or for someone who will say that nothing is wrong with the child. If the chronic anger is not resolved, a parent may continue to project it. Nothing can go right. "After all the time and money...my child is no better." Such a parent feels miserable about his or her circumstances. The other parent reacts to this chronic anger by distancing himself or herself rather than encouraging support and co-operation in helping their son or daughter. The other children feel the anger and wonder why their parent is so upset all of the time (Kendall, 1998).

When a parent's guilt persists, all suffer as well. At times the parent handles the unresolved guilt by becoming overly dedicated to the child or adolescent with ADHD.

Not far under the surface is the anger at having to do so much. Some parents may handle the unresolved guilt by withdrawing from other social and/or family contacts and by totally dedicating themselves to the child. Some parents carry this to the point where they have almost no energy left for relationships with the other children in the family or with their partner. The result is a dysfunctional family and a strained marriage (Silver, 1999).

The reactions of the other children in the family might be made worse because parents expect too much of these children. When the ADHD child gets parents frustrated and angry, parents often cry, yell, hit, withdraw, or pout. Yet if these siblings yell or hit or cry because they are also frustrated and angry with their ADHD sibling, parents often punish or reprimand them. Parents forget these children are human too and are also entitled to these feelings. Some siblings of children with ADHD become worried and feel anxious because of lack of information from their parents. Sisters and brothers may become angry, often fighting with the ADHD child. "How come I have to make my bed in the morning and she doesn't?" or "He broke my toy, and you didn't do anything" or "Why is it that when I do something, I get punished and when he does the same thing, I am told that I have to be more understanding?" (Kendall, 1999).

Another source of anger is the amount of time and energy that parents spend with the child who has ADHD, causing jealousy. Siblings are sometimes teased at school about the ADHD child and they might feel embarrassed to bring their friends home to play because the ADHD child might act silly or become hyperactive. Sisters and brothers may feel guilty too, especially guilty when they are angry and the message from parents is "He

can't help it" or "It's not her fault". Due to feelings of anger or guilt, a brother or sister might act out these feelings against the sibling with ADHD. They might tease and provoke this child to encourage misbehaviour. They might do something themselves and then set up this child to be a scapegoat. As the parent punishes the child with ADHD, this sibling smiles and gets a feeling of revenge (Silver, 1999).

It seems the plight of children with disabilities that a younger brother or sister is not only supernormal and delightful but precocious, quickly passing him or her socially and academically. These siblings have lots of friends. They are praised for their behaviour. They excel in school. The contrast may create a conflict with parents. On one hand, these parents are delighted and proud. On the other hand, these successes make the child with ADHD look even worse. There are no easy ways to prevent some or all of these feelings from surfacing in a family with an ADHD child (Silver, 1999).

The child is seen as a potential system stressor as well as the ultimate recipient of parental response patterns. Parenting itself can pose a source of stress (that is, the system demands introduced by the presence of a child), but stresses are more probable if the child's behaviour or needs are problematic, for example, parents of children who manifest hyperactivity (Barkley, 1981; Mash & Johnston, 1983), may be more prone to stress responses. It is proposed that, just as cognitions act to moderate reactions to other types of stress, they also act to moderate reactions to the potential stress that may be induced by children and parenting. Care-giver cognitions are introduced at two levels:

a) at an initial preconscious level, and

b) at an aware or controlled level of cognitive appraisal.

Precognitions operate at an automatic, unaware level and may be conceptualized as leading the individual to a "perceptual readiness" to attend to particular aspects of the environment (Bruner, 1957; Shiffrin & Dumais, 1981 in Sigel, McGillicuddy-DeLisi, & Goodnow, 1992). Care-giving schemas may be understood as representing this type of cognitive structure.

The eliciting stimulus posed by the child, as filtered through precognitive schematic structures, will subsequently influence both, affective reactions and more aware or deliberate levels of cognitive processing. The presence of "difficult" child behaviour will have different consequences based on differences in these care-giving schemas. More adverse reactions will occur for those parents who have a schematic representation of the care-giving relationship that places the adult at a power disadvantage ("threat-oriented" schema). Such parents focus on the child as a "problem source" and see themselves as a helpless victim of that child (Sigel et al., 1992). This usually results in parents responding with despair and anger.

Younger children, in particular, are likely to interpret "threat-oriented" adults' behaviour toward them as negative and confusing, acting to generate negative affect or anxiety in the child. In coping with their own negative affect, children can be expected to respond with increases in avoidance or unresponsiveness (Kopp, 1989 in Sigel et al., 1992). This pattern in turn acts to support the adult's relationship schema and confirms the validity of their threat- or problem-focused ideation. Ultimately, the system acts not only in a self-

maintaining but also in a potentially escalating fashion. As levels of autonomic arousal and negative affect increase, the system may destabilize and move out of control to expressions of anger or rage. The focus here is on interdependent systems and the ways in which dysfunctional systems are maintained.

2.13 COMMENT

The purpose of this study was to evaluate the experiences of parents' participation in a stress management programme for parents with ADHD children. This chapter provided an overview of the definition and theories on the causes, diagnosis, symptoms and treatment of ADHD, theories on stress, parental stress and parental stress with ADHD children and an understanding on why family systems stress theory has been utilized as the appropriate theoretical framework for this research project. The literature review also includes a section on cognitive-behavioural approaches regarding the causes of stress and its management as this was the approach adopted in the stress management programme utilized in this study.

The following chapter, **Chapter 3,** will discuss the research methodology employed in this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

As mentioned previously, the purpose of this study was to evaluate the experiences of

participants in a stress management programme for parents with ADHD children using an

Appreciative Inquiry (AI) methodology as well as incorporating aspects of process

evaluation. The stress management programme for parents with ADHD children was

evaluated by the participants in this study (the parents), their ADHD children and

psychologists. This chapter will explain the processes involved in data collection for this

investigation.

3.2 RESEARCH APPROACH

The raw material for qualitative research is ordinary language, as opposed to the numbers

that are the raw material for quantitative research. Whatever source it may come from,

linguistic data can give the researcher rich, deep, and complex information, sometimes

referred to as "thick description" (Geertz, 1973). This can be used to understand people's

feelings, thoughts, ways of understanding the world, or ways of communicating with

others.

However, the difference between quantitative and qualitative approaches to research is about more than the difference between numbers and words; it is also about epistemology, the theory of what knowledge consists of. Quantitative research is largely based on the philosophy of positivism (Bryman, 1988). The three main tenets of positivism are:

1. That scientific attention should be restricted to observable facts.

2. That the methods of the physical sciences should be applied to the social sciences (e.g. quantification, separation into dependent and independent variables).

3. That science is objective and value free.

That is, they see reality as objectively given.

Qualitative researchers usually reject positivism, often quite vehemently, instead preferring non-realist epistemological positions based on developing understanding rather than on testing hypotheses. Phenomenologists attempt to understand the person's perception and experiences - their inner world (Bryman, 1988).

This study utilized a qualitative approach due to the fact that the objectives of this study focused on investigating the experiences of participants and qualitative research is the perfect tool to help understand participants' thoughts, feelings, ways of understanding the world, and ways of communicating with others.

3.3 RESEARCH DESIGN

The qualitative deign that was chosen for this study is phenomenology. According to Osborne (1994), the most important thing to remember when doing research is that the method that is chosen "should be a function of the question to be answered rather than allegiance to metatheoretical dogma." Patton (2002) also prefers to distinguish theoretical perspectives by their foundational questions. Patton phrases the foundational question for phenomenology as: "What is the meaning, structure and essence of the lived experience of the phenomenon for this person or group of people?" (Patton, 2002)

The primary focus of this study was to understand and explicate the phenomenon of stress as experienced by parents of children who have been diagnosed with ADHD. The researcher did not enter this research with any preconceived ideas but rather examined participants' experiences and then developed themes of meanings that they attached to them. The worth of this study will be determined by the degree to which it generates theory, description or understanding. The phenomenological approach was deemed appropriate for this purpose as it is a strategy that is used to systematically study people's experiences and ways of viewing the world. Phenomenology is the study of a phenomenon and how people perceive it within the context in which they occur (Barker, Pistrang, & Elliot, 2002).

3.4 PROGRAMME EVALUATION

In everyday parlance, evaluation means judging the worth of something. Much of the early evaluation work was done in the United States in an educational context, where it is known as programme evaluation. It arose as a way of monitoring the federal money spent on large-scale social programmes in the 1960s, such as Head Start, a pre-school educational intervention programme (Rossi, Freeman, & Lipsey, 1999; Shadish, Cook, & Leviton, 1991).

Evaluation, at the applied end of the continuum, differs from pure research in several ways (Barker, Pistrang, & Elliot, 2002):

- Its primary aim is to assist decision making, rather than to add to an existing body of knowledge.

- It is done on behalf of a decision-maker, often a manager, who may be distinct from the evaluator.

- It takes place in a complex "action setting", as opposed to a more controlled academic research environment.

- Its participants are usually users of the service, rather than research volunteers.

- It is intended for immediate use.

- It is often written up for purely local consumption.

3.4.1 TYPES OF EVAUATION

Needs Assessment

Assessing the extent of the target problem in the target population is the first step in

planning a service as it gives an indication of what the volume of demand is likely to be

(Barker et al., 2002). The concept of need is often used in a technical sense, defined as a

problem for which there is a potentially effective intervention. Under this somewhat

counter-intuitive definition, need is assessed by professionals, rather than by users

themselves. It is not determined by the severity of the problem, but by whether something

effective can be done about it. In contrast, demand is defined as what people ask for and

supply as what is provided (Barker et al., 2002).

Scriven (1972) classified evaluation into formative and summative approaches.

a) Formative Approach (Process evaluation)

Formative evaluation, also called process evaluation aims at elucidating and

understanding the internal dynamics of programme operations – the activities that

constitute the service delivery. They focus on the following questions: What are the

factors that come together to make this programme what it is? What are the strengths and

weaknesses of the programme? How are clients brought into the programme and how do

they move through the programme once they are participants. A formative approach is typically used for internal programme purposes, and feeds back its results to influence the service as it continues to develop (or form itself). Formative evaluations are conducted for the purpose of improving programmes (Patton, 1987).

Formative evaluations may focus on gathering descriptive information about the quality of programme activities and outcomes, requiring qualitative data. Thus, to find out what it means to participate in a particular programme, is an issue of quality and it requires descriptions of the participants' perspective and situation such that the meaning of the experience for the participant is recorded (Patton, 1987). Process evaluation was utilized for this study.

b) Summative Approach (Outcome Evaluation)

A summative evaluation provides an overall summary, typically for administrative purposes; it is often done on a larger scale with its results delayed until after the end of the evaluation period. Summative evaluations are conducted to make basic decisions about whether a programme is effective and whether it should be continued (Patton, 1987). Outcome evaluation aims to measure whether and to what extent the goals of the programme have been met.

3.5 APPRECIATIVE INQUIRY (AI)

AI is a change theory developed by David Cooperrider and his colleagues in the 1980s. AI is a form of action research that attempts to create new ideas and images based on positive experiences that aid in the development of change in a social system. AI enables organizations to increase their capacity to make transformational shifts by moving organizations from a deficit- and problem -based approach to one where organizations learn from their most positive and successful experiences. According to Watkins and Mohr (2001), "AI leads systems to move toward the generative and creative images that reside in their most positive core - their values, visions, achievements, and best practices" (p. xxxi).

3.5.1 ORIGINS AND THEORIES OF AI

AI is strongly grounded in the theories and principles of social constructionism (Watkins & Mohr, 2001). Social constructionists share the belief that the world is shaped by conversations and interactions with one another. AI built upon this overarching premise by creating an intervention based on the power of dialogue, generated by inquiry. The act of inquiry shifts the system in the direction of the inquiry by eliciting images created in the dialogue. Therefore, a positive inquiry will engender positive images for the future.

Cooperrider (1996) explains the process aptly in the following quotation:

"The questions we ask, the things we choose to focus on, and the topics we choose determine what we find. What we find becomes the data and the story out of which we dialogue about and envision the future. And so, the seeds of change are implicit in the very first questions we ask" (p. 21).

3.5.2 AI AND PROBLEM SOLVING

AI's approach to change focuses on strength and potential rather than on deficit-based assumptions (Watkins & Mohr, 2001). AI is an inherently positive approach to change. It is important to emphasize that AI does not ignore problems. It deliberately addresses problems in a unique manner. Figure 1 presents the model which contrasts problem solving with AI (Watkins & Mohr, 2001, p. 42).

Problem Solving	Appreciative Inquiry
"Felt Need" *Identification of Problem*	*Appreciating and Valuing* *The Best of "What Is"*
⬇	⬇
Analysis of Causes	*Envisioning "What Might Be"*
⬇	⬇
Analysis of Possible Solutions	*Dialoguing "What Should Be"*
⬇	⬇
Action Planning *(Treatment)*	*Innovating "What Will Be"*
Basic Assumption: *An Organization is a Problem to be Solved*	*Basic Assumption:* *An Organization is a Mystery to be Embraced*

Figure 1

Problem Solving Versus Appreciative Inquiry

3.5.3 IMPLEMENTING AI INTERVENTIONS

Various models are based on AI theory, the model used in the present study was the four-D model (see Figure 2), developed by members of the GEM Initiative in Harare, Zimbabwe, as a model for building partnerships (Watkins & Mohr, 2001). Both, Watkins and Mohr (2001) and Cooperrider (1996) recommend using the four-D model when implementing AI as an intervention tool. The four phases of this model are the discovery phase, the dream phase, the design phase, and the delivery phase (Watkins & Mohr, 2001, p. 43).
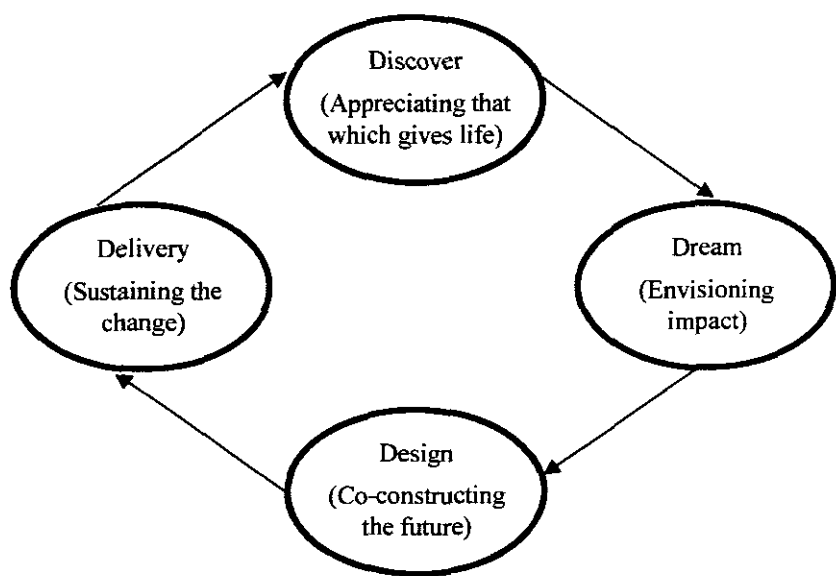
Figure 2

The Four-D Model

Discovery: Appreciating what gives life. The goal of the discovery phase is to appreciate the best of what is by focusing on peak moments of excellence. This is a time when people have experienced feeling most alive and effective (Watkins & Mohr, 2001). Participants identify and learn from even the smallest examples of success while focusing on what gives life and energy. This phase shifts the attention from what is not working to what is working and what might possibly work in the future (Whitney, 1998).

Dream: Envisioning impact. The dream phase encourages participants to challenge the status quo by envisioning a preferred future (Watkins & Mohr, 2001). This phase takes place in a large group during which the data and stories collected in the discovery phase are shared. These inspiring accounts and high moments are generally forgotten by focusing on the deficit or problem. It is the systematic recalling of the emotions that were present during these peak experiences that is at the core of AI.

Design: Co-constructing the future. Participants craft provocative propositions, which bridge the best of what is with one's own speculation or intuition of what might be, during this phase (Watkins & Mohr, 2001). Provocative propositions articulate positive images of the participants' dreams in active terms. While the dream phase encourages possibility thinking, the design phase focuses on actionable steps to realize those dreams.

Delivery: Sustaining the change. Participants conceive of ways of acting on the new images of the future in this final phase. The delivery phase focuses on action planning at the personal level. Commitments are made to ensure the realization of the envisioned

future. This phase is ongoing and characterized by continuing dialogue and a high level of innovation (Watkins & Mohr, 2001).

By employing an appreciative inquiry model to evaluate the stress management programme for parents with ADHD children, the positive aspects of the programme will be highlighted, and ways of improving it will be examined to create a more effective community intervention.

3.6 OBJECTIVITY VERSUS SUBJECTIVITY

Qualitative research is often criticised for not being "objective". Patton (2002) suggests that the terms subjectivity and objectivity be replaced by the phrase "empathic neutrality". He believes that this phrase suggests that there is a middle ground between becoming too involved, which can cloud judgement, and remaining too distant, which can reduce understanding.

According to Patton (2002), any credible research strategy requires that the investigator adopt a stance of neutrality with regard to the phenomenon under study. This simply means that the investigator does not set out to prove a particular perspective or manipulate the research information to arrive at predisposed truths. Rather, the researcher's commitment is to understand the world as it unfolds, to be true to complexities and multiple perspectives as they emerge, and to be balanced in reporting both, confirmatory and disconfirming evidence with regard to conclusions offered.

Guba (1978) has considered the issues of objectivity and subjectivity with special reference to evaluation. He notes that all kinds of evaluation data should be reliable, factual, and confirmable. "There seems to be no intrinsic reason why the methods of a properly trained naturalistic inquirer should be any more doubtful a source of such data than the methods of an investigator using a more quantitative approach" (Guba, 1978, pp. 74-75). Guba (1978) stated that the neutral evaluator is impartial, one who is not predisposed toward certain findings ahead of time. The neutral evaluator enters the field with no axe to grind, no theory to prove, and no predetermined results to support.

3.7 VALIDITY IN QUALITATIVE RESEARCH

Winter (2000), states that some qualitative researchers have rejected the notion of validity, in any form, as entirely inappropriate to their work. Other qualitative researchers, although they argue that the term validity is not applicable to qualitative research, have at the same time realized the need for some kind of quality check or measure for their research. A "valid" account in qualitative research generally refers to the presentation of an account that is sound and grounded in the research information.

In the current study, a literature review pertaining to ADHD, stress and parental stress with ADHD children was conducted by the researcher prior to the collection of research information. Some critics may object to this as this is a procedure generally avoided by phenomenologists, lest the literature should threaten validity by biasing the researcher's perceptions. However, Shantall (1996) argues that a literature review need not lead to

theoretical bias and may in fact enhance understanding and empathy, by opening the researcher's mind and revealing existing pre-conceptions of the phenomenon under study.

3.7.1 TRIANGULATION

Denzin (1978) has identified four basic types of triangulation:

1. Data triangulation – the use of a variety of data sources in a study, for example, interviewing people in different status positions or with different points of view. In the current study, data was collected through several means, from participants and from their ADHD children regarding parent-child interactions after completion of the programme.

2. Investigator triangulation – the use of several different evaluators or social scientists. Consensus among researchers involves trying out interpretations on other investigators and this represents another category for validity in qualitative research (Stiles, 1993). The researcher's promoter and other psychologists in the field who are personal friends with the researcher acted as critics and mentors. This offers readers the assurance that other investigators who were familiar with the raw research information found the proposed interpretation convincing.

3. Theory triangulation – the use of multiple perspectives to interpret a single set of data.

4. Methodological triangulation – the use of multiple methods to study a single problem or programme, such as interviews, observations, questionnaires, and documents.

3.7.2 FACE VALIDITY OF INSTRUMENT

Content validation simply asks the question: "Is the content of the test relevant to the characteristic being measured?" The face validity of a test is simply the subjective evaluation of the relevance of the test items. Having a test with clear face validity may also be useful in obtaining compliance from respondents since, if the content appears irrelevant, the respondents may become irritated. Content validation, then, is largely a qualitative process and it depends upon the researcher having a clearly defined idea of what it is he or she wishes to measure (Breakwell, Hammond &Fife-Schaw, 1995).

3.8. RELIABILITY IN QUALITATIVE RESEARCH

According to Stiles (1993) reliability concerns the procedural trustworthiness of the research. The report should convey what another person who was observing would have seen. It has been noted that the reliability of self-report data differs, depending on the types of questions asked. According to Winter (2000) the definition of reliability is that of "replicability".

3.9 SELECTION OF RESEARCH SITE

This study is based in the Umlazi District, Durban Central Circuit, in the Ethekwini Region in Kwa Zulu-Natal. This particular circuit was chosen on the basis of accessibility, time constraints, and expense as the researcher is an Educational Psychologist in private practice in this region. The study was located at the researcher's rooms in Durban North, more specifically, Effingham Heights. This area is a predominantly Indian suburb of average-high socio-economic status. This area was purposefully selected as the researcher had already received numerous referrals from schools in this region pertaining to the focus of this study.

The researcher handed out pamphlets (see Appendix A) which detailed the nature and content of the stress management programme for parents of ADHD children. The purpose of the study was also indicated. The pamphlets were distributed to the local library, clinic, and a medical doctor's consulting rooms in the Effingham Heights area.

3.10 CONSENT

The original programme was developed and implemented by a team of psychologists in New Zealand and after consulting with them, permission was granted to use their programme for the purposes of this study. Thereafter, the programme was e-mailed to the researcher by Dr. Gail Tripp, Department of Psychology, University of Otago, New Zealand, one of the developers of the programme.

The volunteers who responded to the pamphlet contacted the researcher and appointments were set up to interview them and to obtain signed consent from them (see Appendix B) indicating their willingness to participate in the study. The consent form informed participants of their right to withdraw from the study at any given point in time and it also informed them that all identities would remain anonymous.

3.11 SAMPLING

3.11.1 PARENTS

In qualitative and case study research, the term purposive sampling is often used to denote a systematic strategy of selecting the participants according to criteria that are important to the research questions. It is similar to specifying the target population in quantitative research, in that the researcher attempts to select participants fitting specific criteria, but it is a less rigid process, being guided by the researcher's judgement (Robson, 1993). The power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research (Patton, 2002).

The phenomenological researcher seeks out those who have experienced the phenomenon in question and can communicate their experiences (Osborne, 1994). There are several

strategies for purposefully selecting information-rich cases. In this study the parameters for selection of participants were:

1. They had to be parents, either male or female.

2. They had to be parents of a child (6-18 years) already diagnosed with DSM-IV ADHD.

3. They had to be experiencing difficulty relating to parenting their ADHD child/children.

Initially 14 parents responded to the pamphlet. After the initial interview, only 9 parents were recruited as appropriate participants who met all of the above criteria, as two parents stated that their children were not properly diagnosed with ADHD by a specialist so they were not sure of their diagnoses, one parent stated that her child suffered from stuttering only, and two parents thought that a monetary reward was offered and that was their reason to participate, after being informed that there was no monetary reward, both refused to participate in the programme.

Of the 9 parents, after the first session, 1 father was unable to participate further due to work-related commitments and was subsequently excluded from the group. The final sample of parents consisted of 8 parents, 5 mothers and three fathers.

3.11.2 ADHD CHILDREN OF PARTICIPANTS

Only after the programme was completed, the researcher requested from parents that their ADHD children be interviewed to provide feedback on the parent-child interactions they have observed in the home situation. This allows the researcher to get the views of

someone who knows the person and interacts with him or her and has greater opportunity than the researcher to observe them in their natural setting (Barker et al., 2002). Parents agreed to this request as it related to observed behaviour changes of the parents.

3.11.3 PSYCHOLOGISTS

The researcher identified two psychologists who were willing to evaluate the programme, one for face validity and the other from an appreciative inquiry perspective. One psychologist was requested to evaluate the original format of the programme as it was implemented in New Zealand so as to assist in adapting the programme for our local usage. The other psychologist, also an educational psychologist, was requested to evaluate the adapted programme that was used in the current study. Consent was obtained from both psychologists.

3.12 RESEARCH INSTRUMENTS

3.12.1 BIOGRAPHICAL QUESTIONNAIRE

Parents were required to provide information on the following:

- Age
- Gender
- Marital status

- Ages of children

- Employment status

- Number of ADHD children on medication

- Contact telephone numbers

These were all structured questions with the aim of gathering background information about the participants in this study (see Appendix C).

3.12.2 APPRECIATIVE INQUIRY QUESTIONNAIRE

The questionnaire consisted of 3 open-ended questions:

1. Describe your experience of the programme.

2. What do you appreciate about the programme?

3. How can this programme be improved?

This questionnaire (see Appendix D) was administered to all the participants after completion of the programme. Respondents had to answer these questions from their own personal experiences and perspectives on the programme. The response format was open-ended. The researcher did not supply predetermined phrases and categories that needed to be used by respondents to express themselves, as in the case with fixed-response questionnaires.

It's the difference between asking, "Tell me about your experiences in the programme" and, "How satisfied were you with the programme? Very, somewhat, little or not at all"

(Patton, 2002, p.40). The purpose of the appreciative inquiry questionnaire was to capture the individual experiences of those who participated in the programme, rather than forcing them to fit their experiences into categories.

The great advantage of self-report is that it gives the researcher the respondents' own views directly. It gives access to phenomenological data, that is, respondents' perceptions of themselves and their world, which are unobtainable in any other way. However, it is advisable to supplement self-report data with observational data. In the present study the observational data was obtained by the researcher via an interview with respondents' ADHD children (see Appendix E) which asked respondents' children to describe whether they have noticed any changes in the way their parent (participant in programme) interacts with them recently.

3.12.3 ADMINISTRATION OF QUESTIONNAIRES

In the last session of the programme, participants were each given an appreciative inquiry questionnaire and answer sheets in a sealed envelope and were asked to reflect, over the next week, on the programme in which they have just participated in, and then to fill in the questionnaire. After all questionnaires were returned, the researcher set up appointments with the participants' children for an interview.

3.13 ETHICAL CONSIDERATIONS

It is both, ethically and methodologically, desirable to secure participants' informed, written consent to participate in this study. The consent form for the current study:

- Informed participants about the nature and purpose of this study.

- Informed participants that their participation in this study was voluntary and that they had a right to withdraw from it at any stage.

- Assured respondents that all their responses would be treated with confidentiality and sensitivity.

- Indicated that the results from this study would be included in a thesis and should they wish to read it, it would be made available to them.

3.14 ANALYSIS OF DATA

Data from the appreciative inquiry questionnaires (parents and psychologist) and the interviews with the ADHD children, which comprised open-ended questions, were analysed qualitatively using thematic content analysis. Researchers analyzing qualitative research information strive to understand a phenomenon as a whole. According to Patton (2002), this holistic approach assumes that the whole is understood as a complex system that is greater than the sum of its parts.

In this study, the researcher followed the following method: Qualitative data analysis can be thought of as involving three separate sets of processes, namely: identifying meaning, categorizing, and integrating (Barker et al., 2002). Some approaches, suggest dividing the

data into units before coding. The most common is the meaning unit, which consists of material on a single point in the participant's description.

Identifying Meaning

The researcher begins the formal part of the analysis by going through the data and trying to identify the ideas that are being expressed. That is, before categories can be created, the data must be understood. This is achieved by reading through the manuscripts several times.

Categorising

All forms of qualitative analysis engage in some form of category generation, in which the researcher groups together important concepts or ideas. The previous ("identifying meaning") phase usually results in a tentative set of labels corresponding to the set of ideas in the data; the task now is to organize them conceptually. This process leads to the identification of key concepts, often referred to as categories or themes.

Integrating

As categories begin to emerge from the data, the researcher attempts to make connections between them. The aim is usually to create some sort of conceptual framework, rather

than a list of unrelated categories. Finally, it is important for the researcher to find some way of summarizing the analysis in an integrative way.

3.15 SETTING UP AND CARRYING OUT THE INTERVENTION

After the first psychologist or "expert judge" evaluated the relevance of the original format of the stress management programme as it was implemented in New Zealand, the necessary changes were made to the programme and it was successfully adapted for use in the current study.

3.15.1 PROCEDURE

After the sample was selected, and the necessary consent obtained, session times and dates were finalized. The parent stress management group met for 9 consecutive weeks at the researcher's practice. Sessions were run in the evenings and were two hours in duration, including a short refreshment break.

Table 1 summarises the programme sessions according to topics.

STRESS MANAGEMENT PROGRAMME FOR PARENTS OF ADHD CHILDREN

SESSION	TOPIC
One	Stress
Two	Education
Three	Resources
Four	Problem Solving Skills
Five	Cognitive Restructuring
Six	Communication Skills
Seven	Self Care Skills
Eight	Behaviour Management
Nine	Wrap-up Session

Table 1: Stress Management Programme - Sessions and Topics

3.15.2 PROGRAMME STRUCTURE AND CONTENT

Each group session, with the exception of the first, began with a review of the previous session, including homework. This was followed by a presentation by the group leader (researcher) and a group discussion. Parents then paired up to complete exercises designed to demonstrate and reinforce the material presented. Finally, homework

exercises were presented and discussed. At the end of each session, parents were provided with a handout of the material covered. Throughout all sessions parents were encouraged to ask questions and raise relevant issues for discussion. In all sessions teaching examples focused on issues surrounding parenting and living with a child with ADHD. The underlying premise of the Parent Stress Management Programme is that if the programme is effective in treating and managing parenting stress of the participants then it is hypothesized that the relationship between parent-child interactions would improve, resulting in more positive child-behaviours.

Session content is described below.

SESSION I - Orientation to the program and understanding stress

This session was designed to orient parents to the program, to establish group rules, and to educate parents about the nature and effects of stress. The latter included a description of the nature of stress and how to recognize it; the stresses associated with parenting a child with ADHD; the effects of stress on parents and their parenting practices; and effective and ineffective ways of managing stress. Parents completed exercises to help them identify their current stressors, the effects of stress, and their current coping strategies. This session aimed to enhance parents' recognition of stress generally and the unique stressors involved in parenting a child with ADHD.

SESSION 2 – Education about ADHD

This session focused on providing parents with accurate information about the nature and treatment of ADHD. Topics covered included the history of ADHD, presumed causes, core symptoms and associated difficulties, adolescent and adult outcomes, and treatment options for ADHD. Parents were encouraged to ask questions, provided with details on where to obtain further information about ADHD, and given handouts to help them inform others about ADHD. This session aimed to correct any parental misperceptions about the disorder, help parents generate realistic expectations of their child, and to empower them in discussing their child's difficulties with others.

SESSION 3 – Resources

This session provided parents with information on their child and family's educational entitlements and available community resources. By increasing parents' knowledge in this way, the session sought to reduce the frustration they experience in seeking help and to increase the likelihood that the necessary assistance would be obtained.

Fundamental changes are being affected in South Africa in one of the most pivotal activities of the South African community, i.e. the field of education and training. New directions in government policy, the acceptance of the Bill of Rights in a new constitutional environment, the desegregation of schools and a general movement away from the outdated system of single medium schools have found their way into education

for the disabled child as well. Within a short space of time, most 'traditionally privileged' schools have become faced with bigger classes, with learners from a variety of cultures and with an extremely diverse learner population, including children with diverse disabilities (Lomofsky, Roberts & Mvambi, 1999).

In theory, there appears to be many advantages to inclusive education, however, the reality is that ordinary schools find it difficult to take up this challenge. The available facilities and finances are simply inadequate to accommodate learners with disabilities in ordinary schools. In South Africa the following act as barriers to learning when a child with a disability, including ADHD, attends a school in a disadvantaged area:

- Poverty and under-development, as a result of unemployment and which means limited access to basic services. Communities in disadvantaged areas often suffer from limited teaching facilities, big classes with high learner/teacher ratios, under-trained staff and inadequate teaching environment in terms of intervention for the child with ADHD.

- A rigid curriculum in which the diverse needs of all learners are not addressed.

- Negative attitudes towards disability in communities.

- Limited parental involvement because of the absence of parents.

- Lack of appropriate training of teachers to enable them to deal with diversity in the classroom.

- Limited support structures for teachers. Long distances between schools and impassable roads in many service areas are realities that further complicate the situation.

The above issues pose the question as to the feasibility of successful inclusion of the child with ADHD. The possibility arises that these children will be regarded as learners with specific educational needs for whom other 'special' alternatives, with all the disadvantages of alienation, segregation, high financial costs and potentially inadequate teaching standards, unfortunately always have to be created.

SESSION 4 - Problem-solving Skills

This session presented a rationale for adopting a problem-solving approach together with problem-solving skills. The group leaders described and demonstrated the steps of problem identification, problem specification, solution generation, evaluation of alternative solutions, implementation of chosen solutions, and outcome evaluation. The solving of current ADHD-related difficulties was emphasized within session and as part of the homework exercises. Providing parents with problem-solving skills was designed to enable them to generate adaptive responses to stressful situations, thereby increasing their sense of self-efficacy and control.

SESSION 5 – Cognitive Restructuring

In this session parents were taught the link between thoughts, behaviors, and emotions. Common cognitive errors were identified and their effects on emotions and behavior discussed. Parents were assisted in identifying and challenging their own faulty cognition and replacing them with more adaptive thoughts. This component of the program aimed

to help parents develop more realistic expectations of their children and themselves, reduce emotional arousal when expectations are not met, and reduce the negative impact of unhelpful comments from others.

SESSION 6 - Communication Skills

This session focused on identifying dysfunctional patterns of communication between parents and their children, partners, extended family, and health and education professionals. Effective communication styles were described and modelled. Topics covered included giving effective commands to children with ADHD, enhancing communication between partners, and communicating effectively with school personnel and health professionals. It was hoped that improved communication skills would facilitate child compliance and positive parent-child interactions, increase the likelihood of parents meeting one another's needs, and increase the likelihood that the child's needs would be identified and addressed by appropriate professionals.

SESSION 7 - Self-care Skills

This session addressed the importance of self-care in the reduction of stress. Time-management skills and relaxation techniques were introduced and practiced in session and parents were encouraged to utilize these skills at home and work. Time-management skills aimed to guide parents in establishing a balance between the competing demands of

children, partners, and work and their own needs. Relaxation skills aimed to help reduce psychological and emotional arousal when experiencing stress.

Session 8 - Parenting Skills

This session briefly reviewed the use of behaviour management techniques with children and adolescents, in particular, the appropriate use of discipline. The session was designed to increase parents' awareness of punitive parenting practices, and to help them use the skills already taught to deal more appropriately with their child's difficult behaviors. Although not intended, or presented, as a substitute for attending a parenting program, it would be considered unethical not to address the use of discipline practices with parents experiencing high levels of parenting stress.

SESSION 9 - Wrap-up Session

This final session was used to complete the discussion of parenting skills, review the material covered in the previous eight sessions, and answer any remaining questions. Participants will be handed appreciative inquiry questionnaires.

In summary, the programme is designed to address the characteristics of the child (ADHD symptoms, associated difficulties), the parent (mood, cognition, parenting efficacy), and the environment (parental relationship, available social support) thought to contribute to elevations in parenting stress. Session content focuses on the provision of

accurate information to assist parents in developing realistic expectations of their children together with skill training to reduce emotional arousal and to improve communication and problem solving. The group format, in addition to being cost-effective, offers parents the opportunity to discuss their concerns with others facing similar difficulties, potentially increasing their actual and perceived social support.

3.16. THE HELPING PROCESS

There are considerable benefits to be gained from using a group setting in the pursuit of personal development. Initially, a client may join the group with deep feelings of isolation, but discover that others have encountered similar problems and can share such feelings. This can bring a great sense of relief as they begin to realise that they are not alone or unique.

Often clients have a very poor self opinion or image of themselves and this usually leads to feelings that they have nothing of value to offer to others. By encouraging listening and sharing, morbid pre-occupations with the self can be avoided. The ability to give to others is valuable in the healing process and increases feelings of self-worth (Duboust & Knight, 1995).

The group setting can also be seen as an educational one where, for example, in a stress management programme, symptoms of anxiety and the way these affect us physiologically and emotionally can be discussed, so helping to allay any irrational

beliefs or fears. Advice from others even if not useful, can be seen as a caring gesture. Feedback from other group members can be useful in helping develop social skills, as we learn from others how our attitudes and mannerisms are interpreted. Role play may be used to act out specific problem areas, using other members to represent figures in our lives. This allows testing to go on in a safe environment (Duboust & Knight, 1995).

Seeing how others cope with similar situations to our own may be useful and lead to experimentation with alternative coping mechanisms for ourselves. For people who find it difficult to form close relationships, the group provides a safe environment to start. This is made possible by honest and open feedback from others which at the same time sustains acceptance and rapport.

The group is an ideal setting for discovering how we are seen by others, how our behaviour affects others and why we behave in certain ways. By gaining this understanding, we can set in motion the wheels of change.

3.16.1 EFECTIVE GROUP LEADER BEHAVIOURS

The counsellor's role in a group is diffused and complex. The counsellor must be able to respond sensitively and empathically to each individual while observing other members' reactions to the communication. The counsellor must also be able to observe group dynamics and have the skills to process the complex interaction that occurs in the group

(Corey & Corey, 1977). According to Corey and Corey (1977), the following are the most effective group leadership skills:

- **Listening**

Effective listening is composed of two basic skills: restatement of content (or paraphrasing) and reflection of feeling. The effective group leader fully tunes in to the client's message and responds to much more than the spoken word. Listening builds trust and communicates the counsellor's acceptance of the client.

- **Perception Check**

A perception check conveys that the counselor wants to understand he client's feelings and is literally checking out his or her perception of the client's experience. In a perception check, the counselor accurately labels the client's feeling and then asks whether or not the perception is accurate.

- **Feedback**

Since a therapeutic goal of group counseling is to learn how one comes across to others, the counselor must give feedback to group members. Feedback should be "descriptive" rather than "evaluative". It must identify the specific behaviours.

- **Linking**

Through the skill of linking, the leader relates the concerns or statement of one group member to those of another in the group. In essence, linking points out the commonalities of experience among group members in an attempt to encourage member-to-member communication.

- **Open-ended Leads**

Using open-ended leads or questions in groups can force the members to be very specific about feelings and the sources of these feelings. They also enable the counsellor to focus on events or experiences that bring the discussion into the here and now. What and how questions are more useful than why questions.

- **Confrontation**

Confrontation can be the most powerful leader skill when used with sensitivity and care. The counsellor might choose to confront discrepancies in an individual's verbal and non verbal behaviour; he or she might confront behaviour that disrupts the group's functioning. The counsellor may also choose to confront the group as a whole.

- **Process Skills**

An effective group leader must have the ability to observe the process by which the group is functioning and be prepared to comment on it as it relates to the group goals. The counsellor can begin by asking group members what has happened during a session and then might comment on the dynamics of the session (process evaluation).

- **Summarisation**

As in individual counselling, summaries have an important place in the group process. The group leader listens carefully to all the interaction in the group and uses a summary to help the group move to a different level of interaction. A summary is also useful when the group becomes bogged down.

- **Overall Responsibilities**

The role of the group leader is much more comprehensive than a listing of essential skills might suggest. The group leader may find it necessary to share information regarding effective and ineffective communication. He or she has the responsibility to be sure everyone owns their own feelings and asks for feedback from other members. Possibly the most important requirement of the group leader role is to model effective communication skills and appropriate group behaviours. As group members observe

the leader's use of effective communication skills, they will be able to assume more responsibility for the group.

- **Therapist Variables**

a) Attitude to the client. These include: interest, empathy, warmth, sympathy, liking, friendliness.

b) Attitude to therapy. These include: enthusiasm, conviction, commitment, interest, belief, faith, optimism.

c) Attitude toward results. Experimenters (and therapists) may 'obtain' the results they want to expect.

3.17 TECHNIQUES FOR FACILITATING CHANGE

Cognitive therapy is based on the notation that thinking plays a role in the aetiology and maintenance of different disorders. Basically, cognitive therapy approaches seek to reduce distress by changing maladaptive beliefs and providing new skills. The label of cognitive therapy takes in a wide group of techniques and schools which are not always easily reconcilable. The accent on the importance of cognitive processes as agents of distress, or the necessity for changes at the level of thought, and not only in behaviours, are insufficient ingredients to be able to talk about a convergent theoretical corpus (Brammer & Macdonald, 1996).

3.17.1 BEHAVIOURAL TECHNIQUES

Common behavioural techniques in cognitive therapy include:

- **Scheduling Activities**

The purpose of these is twofold:

i)   to increase the probability that the client will engage in activities that he/she

        has been avoiding, and

ii)   to remove decision-making as an obstacle in the initiation of an activity. The

        activities that are scheduled can come from three domains; (1) those that were

        associated with mastery, pleasure, or good mood during self-monitoring, (2)

        those that had been rewarding in the past but that the client has been avoiding

        more recently, and (3) new activities agreed upon by the client and the

        therapist that may be rewarding or informative (Derubeis & Beck, 1988 in

        Brammer & Macdonald, 1996).

- **Task Assignments**

Apart from mastery and pleasure tasks, the therapist may suggest goal-oriented

activities. The success of the client in performing programmed and graded activities

is sought by means of "graded tasks". Success, then, should be explicitly credited to

the client's skill and effort, thus helping to sell the client the idea that it is possible to

carry out cognitive therapy on a self-directed basis in the future (Derubeis & Beck,

1988 in Brammer & Macdonald, 1996).

3.17.2 COGNITIVE TECHNIQUES

Common cognitive procedures in cognitive techniques include:

1. Daily Record of dysfunctional thoughts: Much of the work in cognitive techniques is

centred around the use of a device called the Daily Record of Dysfunctional Thoughts

(Beck, 1976). The four most important elements of this device includes situation-

emotion(s)-automatic thought(s), correspond to the three points in the cognitive model

(situation, belief, emotional consequence) plus the alternative or counter response to the

beliefs (rational response).

2. Three questions: there are three kinds of questions that can be asked of inferences,

which serve a heuristic function for clients while they learn the methods of cognitive

techniques: (1) "What is the evidence for and against the belief?", (2) "What are the

alternative interpretations of the event or situation?" and (3) "What are the real

implications, if the belief is correct?".

3. Cognitive errors: these labels are used to remind clients that they are prone to various

forms of exaggeration and other biased thinking. Moreover, the client can discount the

improbable or illogical inference, reframe it in a less extreme form, or analyse the

inference using the 'three questions' (Beck, 1976).

4. Identifying schemata: The Dysfunctional Attitudes Schedule (DAS) is an assessment device that can be used to tap these underlying assumptions or schemata, and to track change during and following treatment (Beck, 1976). The eight factors obtained from this instrument allow the client and therapist to look at the most idiosyncratic patterns. These factors are as follows: vulnerability, attraction/rejection, perfectionism, imperatives, approval, dependence, autonomous attitudes and, finally, cognitive philosophy.

3.17.3 PROBLEM SOLVING

Although research discloses wide differences among individuals in how they solve problems, there is a remarkable degree of agreement among various theorists and researchers about the operations involved in effective problem-solving (Brammer & Macdonald, 1996). Problem-solving is "a behavioural process, whether overt or cognitive in nature. As D'Zurilla himself has pointed out (1988 in Brammer & Macdonald, 1996) that social problem-solving is at the same time social-learning process, a self-management technique, and a general coping strategy, and this is so because problem-solving is a structure of change, a framework that the therapist must transmit to the client so that the latter can have transtemporal and transituational tools of control available.

To be more precise, the problem-solving process implies five phases:

1. Problem orientation (PO).

2. Problem definition and formulation (PDF).

3. Generation of alternative solutions (GAS).

4. Decision making (DM).

5. Solution implementation and verification (SIV).

Problem Orientation (PO)

The objectives of this stage are to (i) increase sensitivity to problems and set the occasion for problem-solving activity, (ii) focus attention on positive solving expectations and activities and away from unproductive worries and self-preoccupying thoughts, (iii) maximise effort and persistence when obstacles and emotional distress are encountered, and (iv) minimise emotional distress while maximising positive emotional states. The goal of this stage is, moreover, to foster in the client a constructive "set" or attitude toward problem-solving. The more central stages of the problem solving process are described below.

Problem Definition and Formulation (PDF)

This phase has the following objectives: (i) gathering all pertinent information available about the problem in specific terms, (ii) clarifying the nature of the problem, (iii) separating facts from questionable assumptions, (iv) setting a realistic problem-solving goal, and (v) to reappraise the significance of the problem for personal/social well-being. As Goldfried (1977) pointed out, the person must define all aspects of the situation operationally, and formulate or classify elements appropriately.

Generation of Alternative Solutions (GAS)

Generating alternative solutions is considered to be at the core of problem-solving. The major task during this stage is to come up with a range of possible responses, among which, effective ones may be found (the "brainstorming" method). We should not forget that the first solutions to come to mind when trying to solve a problem are not always the best solution. Guiding principles include:

1. Defer judgement: more quality solution ideas will be produced when the problem-solver suspends judgement or critical evaluation of the ideas until later on in the problem-solving process.

2 .Quantity breeds quality: the quantity principle states that the more alternative solutions that are produced, the more quality ideas will be more available. The greater the number of ideas, the greater the likelihood of useful ideas.

3. Combination and improvement: client and therapist should suggest how ideas can be turned into better ideas, or how two or more ideas can be joined into yet another idea.

4. Strategies before tactics: first generate general directions one might take (strategies), then specific ways (tactics) to implement the strategies.

Decision Making (DM)

The main objective in this phase is to objectively evaluate by judging and comparing the available solution alternatives and selecting the best solution for implementation in the

actual problematic solution. The best solution is the one that is expected to be most effective in achieving the problem-solving while maximising significant costs, both personal and social in the immediate as well as the long-term. The client is instructed to judge each available solution and then to ask three questions:

1. Is the problem solvable?

2. Do I need more information before I can select and implement a solution?

3. What solution or solution combination should I choose to implement it?

If the problem is appraised as unsolvable or the answer to the second question is positive, the client must return to the problem definition. However, if the client answers "yes" and "no" to the first question and second question respectively, then the third question can be focused upon and a solution plan formulated.

Solution Implementation and Verification (SIV)

The objective at this stage is to assess the solution outcome and verify the effectiveness or utility of the chosen solution in the actual problematic solution. At this point in the process the elements that should be included are:

1. Performance: the client tries to execute the selected solution.

2. Evaluation: the client, helped by the therapist, compares results to goals; if the results are satisfactory they move on to another problem.

Problem solving therapy is a prescriptive, not descriptive, model of problem solving. For clients who are not used to approaching personal problems so systematically, it may be

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necessary at first to be highly didactic. Gradually, the client should be able to see the techniques as effective and can take over the direction of the problem- solving method, with the therapist becoming more of a consultant.

3.17.4 COPING STRATEGIES

In the decade of the seventies a concept already studied in previous years (Lazarus, 1966) appeared with a great interest for the field of cognitive therapies. This concept was stress. Although many authors have, in one way or another, contributed with different conceptualisations of this term, it is Lazarus who has, without doubt, best systematised his definition. Lazarus (1981) defined psychological stress as a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being. This definition accentuates the importance of appraisal in the comprehension of the stress and consolidates the inclusion of cognitive techniques conceptually to cope with the stress.

Lazarus recognizes that it is true that extreme environmental conditions result in stress for nearly everyone, just as certain conditions are so noxious to most tissues or to the psyche that they are very likely to produce tissue damage or distress. But even in these extreme conditions there are great variations between human beings. A large number of these variations can probably be explained by taking the individual's variables (e.g. personality) and the generic environmental properties of stress into account.

Lazarus proposes two person characteristics that are important determinants of appraisal: commitments and beliefs. Beliefs determine how a person evaluates what is happening or is about to happen. They often operate on a tacit level where the impact of beliefs can be observed when there is a sudden loss of belief or a conversion to a different belief system. For Lazarus, situation and person factors are always interdependent, and their significance for stress derives from the operation of cognitive processes that lend weight to one in the context of the other.

Lazarus identifies cognitive-coping styles as another person variable that can modify stress. Lazarus (1981) defined coping as constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. This definition implies, fundamentally, a distinction between coping and automated adaptive behaviour by limiting coping to demands that are appraised as taxing or exceeding a person's resources. Indeed, this limits coping to conditions of psychological stress, which require mobilization and excludes automated behaviours and thoughts that do not require effort. The manage idea can include minimizing, avoiding, tolerating, and accepting the stressful conditions (emotion-focused coping) as well as attempts to master the environment (problem-focused coping).

3.17.5 STRESS INOCULATION TRAINING

In 1977 Meichenbaum systematized an approach which he named stress inoculation training, this approach being modified slightly in 1985. For him, stress inoculation training involves three phases:

1. The first phase – Educational phase or Conceptualisation phase – is designed to provide the client with a conceptual framework for understanding the nature of his or her stressful reactions.

2. In the second phase, Skills acquisition and Rehearsal, a number of behavioural and cognitive coping skills are offered for the client to rehearse.

3. In the third phase, Application and follow-through, clients are given an opportunity to practice coping skills during exposure to a variety of stressors.

3.18 CONCLUSION

This chapter focused on an in-depth discussion of the theory, research methodology, measuring instruments, and methods of data collection. Chapter four will look at the analysis of the data.

CHAPTER 4

RESULTS AND ANALYSIS OF DATA

4.1 INTRODUCTION

The links between elevated parenting stress, disruptions to the parent-child relationship, and parenting practices argue for treatment programmes that reduce parenting stress in the families of children with ADHD. Although the importance of considering parents' psychological functioning in the management of ADHD has been acknowledged for some time (e.g., Anastopoulos et al. 1992; Anastopoulos, Shelton, DuPaul & Guevremont, 1993), few studies have addressed this issue directly (as noted in chapter two).

Treacy, Tripp, & Baird (2005) assessed the ability of a group-administered parent stress management (PSM) programme to reduce the parenting stress and to improve the mood, family functioning, parenting style, locus of control, and perceived social support of mothers and fathers of children with DSM-IV ADHD. The current study is based on this programme. This programme was adapted for local use and instead of measuring quantitative outcomes of this programme, as Treacy, Tripp, & Baird (2005) did, the researcher was more interested in the qualitative effects of the programme as experienced by the participants.

The original programme utilized quantitative measuring instruments such as: the Parenting Stress Index, the Beck Depression Inventory, the Parenting Scale, the Parental Locus of Control Scale, the Family Assessment Device, the Locke-Wallace Marital Adjustment Test, the Brief Social Support Questionnaire, and the Consumer Satisfaction Questionnaire. All of these measurements were administered pretest and posttest. The results of this study suggest that the PSM programme offers great benefits to parents of children with ADHD. For mothers of children with ADHD, completion of the PSM programme was associated with significant reduction in parent-domain parenting stress together with significant improvements in parenting style. Completion of the programme for fathers resulted in only one significant change: a reduction in verbosity scores (Treacy, Tripp, & Baird, 2005). The research presented in this chapter focuses on parents' experiences of participating in the parent stress management programme.

4.2 DESCRIPTION OF SAMPLE

The final sample in this study consisted of 8 parents, 5 mothers and 3 fathers. Three married couples, both mothers and fathers participated, and two divorced mothers. All participants filled in a biographical questionnaire (refer to Appendix C). The questions on the questionnaire concern the identifying characteristics of the person being interviewed. Answers to these questions help the researcher locate the respondent in relation to other people. Age, occupation, marital status, and the like are standard topics for background questions (Patton, 1987). The questionnaires were analysed descriptively. Frequencies and percentages were calculated for the total sample for all questions on the biographical

questionnaire. The following tables describe the sample of parents who participated in this study:

4.2.1 AGE

The range of the age distribution of parents in this study was 30-50 years. Table 4.1 indicates that 25% of parents fell in the 30-35 year age group, 25% were between 36-40 years old, 25% were between 41-45 years old and 25% fell in the 46-50 year age group.

Table 4.1 Profile of parents according to age

AGE	FREQUENCY	PERCENT
30 – 35 Years	2	25%
36 – 40 Years	2	25%
41 – 45 Years	2	25%
46 – 50 Years	2	25%
TOTAL	8	100%

4.2.2 GENDER

The sample contained an unequal distribution of 5 females (63%) and 3 males (37%). The data is in keeping with research findings which suggest that a number of fathers

attend parenting stress programmes to support their partners, not because they were

seeking help in managing their parenting stress. As already noted in chapter 2, in the

majority of studies, it has been noted that the primary care-taking role belonged to

mothers, possibly contributing to their greater distress.

Table 4.2 Profile of parents according to gender

GENDER	FREQUENCY	PERCENT
Male	3	37%
Female	5	63%
TOTAL	8	100%

4.2.3 MARITAL STATUS

With regard to marital status, 6 participants in this study were married and 2 were

divorced. Increased marital conflict, separations, and divorce, as well as maternal

depression, is also prominent in parents of ADHD children (Befera & Barkley, 1984;

Barkley, Fischer, Edelbrock, & Smallish, 1990; Cunningham et al., 1988; Lahey,

Piacentini, McBurnett, Stone, Hartdagen, & Hynd, 1988; Taylor, Sandberg, Thorley,

Giles, 1991).

Table 4.3 Profile of parents according to marital status

MARITAL STATUS	FREQUENCY	PERCENT
Married	6	75%
Divorced	2	25%
TOTAL	8	100%

4.2.4 NUMBER OF CHILDREN

Four participants (50%) in this study reported having only one child, the ADHD child 25% of participants reported having two children, and two participants (25%) had three-children families. The interaction conflicts in families with ADHD children are not confined only to parent-child interactions. Increased conflicts have been observed between ADHD children and their siblings relative to normal child-sibling dyads (Mash & Johnston, 1983; Taylor, Sandberg, Thorley, & Giles, 1991).

Table 4.4 Profile of the number of children in each family

NUMBER OF CHILDREN	FREQUENCY	PERCENT
One Child	4	50%
Two Child	2	25%
Three Children	2	25%
TOTAL	8	100%

4.2.5 PARTICIPANTS' EMPLOYMENT STATUS

In this study, 75% of participants reported being currently employed at the time of filling in the questionnaire, while twenty five percent reported being unemployed. Many studies report on situations where, for many people, conflict is not escapable, involving wives and mothers who are employed outside the household (Pearlin, 1975a in Kaplan, 1983). These are people who traditionally have been viewed as vulnerable to stress between work and family roles. Aside from problems women encounter on the job, on one hand, and demands of their housework, their marital roles, and their parental roles on the other. As could be expected, the more the job is in conflict with these familial roles, the more likely women are to be depressed.

Table 4.5 Profile of parents according to employment status

EMPLOYMENT STATUS	FREQUENCY	PERCENT
Employed	6	75%
Unemployed	2	25%
TOTAL	8	100%

4.2.6 ADHD CHILDREN AND MEDICATION

Twenty five percent of parents indicated that their ADHD child is on ADHD medication (Ritalin), 25% of parents reported that instead of Ritalin, their children are on herbal medication, and 50% of parents refused to put their children on any medication due to the negative side-effects associated with it.

Table 4.6 Profile of the number of ADHD children on medication

MEDICATION STATUS	FREQUENCY	PERCENT
Takes ADHD Medication	2	25%
Takes Herbal Medication	2	25%
No Medication	4	50%
TOTAL	8	100%

4.2.7 NUMBER OF ADHD CHILDREN IN EACH FAMILY

Seventy five percent of participants reported having only one child diagnosed with DSM-IV ADHD. The remaining 25% of parents reported having two children diagnosed with ADHD.

Table 4.7 Profile of the number of ADHD children in each family

NUMBER OF ADHD CHILDREN	FREQUENCY	PERCENT
1 Child	6	75%
2 Children	2	25%
TOTAL	8	100%

4.3 MEASURE OF FACE VALIDITY - RESPONSE OF PSYCHOLOGIST I

Psychologist one, who is an educational psychologist in private practice, was asked to evaluate the stress management programme for parents of ADHD children in its original form as it was implemented in New Zealand. The psychologist made the following recommendations:

- *This programme is very well integrated, very informative and user-friendly, an excellent tool to be used in combination with other treatment approaches in managing parental stress with ADHD children, either individually or when working with groups.*

- *This format of the programme is too quantitative for my liking. Since the effectiveness of this programme has already been measured quantitatively, a strong recommendation would be a qualitative analysis of both, the processes experienced by participants during individual sessions (process evaluation) and an appreciative inquiry after completion of the programme.*

- *The results of this programme already speaks of its success as a method, so why test its effectiveness again? Rather, others interested in this phenomenon might be more interested in the in-depth, descriptive experiences of participants in the programme, I know I would be.*

- *Also, session three (Resources) needs to be adapted for our South African sample as the list of resources in this session pertain to New Zealand.*

- *When choosing your sample, make use of a set of criteria for appropriate participants or you would have too many inappropriate participants in your sample.*

- *Finally, the choice is yours, what are you aiming to do? Are you planning on evaluating the effectiveness of the stress management program as a tool for reducing parental stress with ADHD children or are you evaluating the experiences of participants in the programme? If the former, then go more quantitative but, if the later, then qualitative is more appropriate.*

After this response from Psychologist one, the researcher went about adapting the programme for appropriate usage with a South African sample. The focus of this study was decided thereafter as qualitative, that is, the researcher was more interested in examining parents' experiences of this programme rather than measurement of any sort. The effectiveness of the programme was gauged by participants' responses to the appreciative inquiry questionnaire, Psycholgist two's responses and the interview with the ADHD children of participants.

4.4 PARENT STRESS MANAGEMENT PROGRAMME EVALUATION

The purpose of this study was to evaluate parents' experiences of participating in the parent stress management programme for parents with ADHD children. The methods used to achieve this objective, was process evaluation and appreciative inquiry. The

appreciative inquiry component was administered to all participants in the programme and a psychologist after completion of the programme. As already noted in chapter 3, data was also collected from the ADHD children of these participants to verify/confirm data presented by parents.

As the researcher was implementing this programme for the first time, process evaluation was chosen as the appropriate evaluation technique and the reasons for this decision have already been mentioned previously in chapter 3. The "process" focus in an evaluation implies an emphasis on looking at how a product or outcome is produced rather than looking at the product itself; that is, it is an analysis of the processes whereby a programme produces the results it does. Process evaluation is developmental, descriptive, continuous, flexible, and inductive (Patton, 1987). A discussion at the end of every session formed the process evaluation component for this study and this will be followed by the appreciative inquiry analysis and an analysis of the interview with the ADHD children.

PARENT STRESS MANAGEMENT PROGRAMME

Each group session, with the exception of the first, began with a review of the previous session, including homework. This was followed by a presentation by the group leader (researcher) and a group discussion. Parents then broke into smaller groups to complete exercises designed to demonstrate and reinforce the material presented. Finally, homework exercises were presented and discussed. At the end of each session, parents

were provided with a handout of the material covered. Throughout all sessions parents were encouraged to ask questions and raise relevant issues for discussion. In all sessions teaching examples focused on issues surrounding parenting and living with a child with ADHD. Session content is described below.

AIMS OF THE PROGRAMME

- To teach parents about stress

- To provide parents with information about ADHD

- To explore resources available to parents of children with ADHD

- To teach parents problem solving skills

- To explore how thoughts and feelings can influence responses to stress

- To teach self-care skills

- To teach effective communication skills

- To review the basic principles of behaviour management

SESSION 1: ORIENTATION TO THE PROGRAMME AND THE UNDERSTANDING OF STRESS

OBJECTIVES:

- To establish group rules

- Educate parents about the nature and effects of stress

In the first session, the focus was on the nature of stress and how to recognize it, the stresses associated with parenting a child with ADHD, the effects of stress on parents and their parenting practices, and the effective and ineffective ways of managing stress. The exercises helped parents identify their current stressors, the effects of stress, and their current coping strategies.

Discussion

The participants in this programme conceptualized stress in terms of physical and emotional symptoms. The physical symptoms included extreme exhaustion, lack of rest, body aches and pains, no time to unwind, and not being able to cope with household chores, working a full-time job and taking care of the children. The emotional symptoms included getting extremely angry and frustrated, feeling depressed and crying for no apparent reason, impatience, feeling neglected and misunderstood, and wanting to just "give up". This is in keeping with the list of physical and emotional symptoms of parental stress as indicated in other research studies which listed some of the following symptoms and signs of stress:

Physical symptoms:

- Sleep disturbances

- Back, shoulder, or neck pain

- Tension or migraine headaches

- Muscle tension

- Fatigue

Emotional symptoms:

- Nervousness

- Anxiety

- Depression

- Irritability

- Moodiness

- Frustration

- Over-reactions

These emotional symptoms are uncomfortable and can affect your performance at work or your relationships with others. Given that the participants mentioned experiencing *several symptoms of stress is indicative of the presence of stress in their lives.* Regarding the exercise on the effects of parent stress to others, most participants mentioned deterioration of relationships with family, friends, colleagues at work and neighbours. They have been accused of being anti-social by family and friends. They reported being almost always involved in arguments with others, no patience when waiting in queues at the shops or in traffic and not participating in their child's school

activities for parents. The parents believe that "others don't understand that they have no energy or time for "luxuries" such as visiting friends and family or socializing with friends as their lives are too stressed and taxing with their ADHD children". Some parents stated "not wanting to be embarrassed in public by their children's inappropriate behaviours", so they rather "avoid social events altogether."

The discussion on parents' sources of stress was exhausting but the most salient points were categorized into three themes:

1. Social problems with ADHD children – which included: not being able to play nicely with their peers without getting into fights and arguments, not being able to accept "no" for an answer, having no control or limits nor any fear, destroying the property of others, being bossy and demanding, always wanting to have things their way, if not, they throw tantrums, even in public places. Pelham and Bender (1982) once estimated that more than 50% of ADHD children have significant problems in social relationships with other children.

ADHD children tend to be very "controlling" in their interactions with peers and the parents of other children misunderstand these behaviours of ADHD children and label them as "naughty" and "spoilt" and warn their own children to stay away from these ADHD children. This in turn renders the ADHD child without much social acceptance and therefore, no friends. Most parents in this study commented that their ADHD children were often "teased" and "labelled as retarded by other children".

2. School-related stresses – Parents appeared to experience predominantly negative

emotions when interacting with school personnel. Parents felt frustrated and exhausted

attending parent meetings only to discover "your child has been in trouble again for...."

and as for "homework not being completed", this is a vicious cycle of heated arguing

between parents and teachers. Some parents were frustrated by the lack of knowledge and

understanding displayed by school personnel regarding ADHD. Parents also felt

extremely angry over the type of comments teachers make about their children.

Comments by teachers included: "your child is difficult/disruptive/can't do anything,

never does his homework, never listens". One mother commented that her son's grade

two teacher made his life a "living hell" to the point where "he refused to go to school".

3. Family stresses – Increased marital conflict, separations, and divorce, as well as

maternal depression is also prominent in parents with ADHD children (Befera & Barkley,

1984; Barkley, Fischer et al., 1990; Cunningham et al., 1988; Taylor et al., 1991). Most

of the parents in this study have experienced, at some point or the other, conflicts in their

interactions with their spouses because of their ADHD child. One mother told the group

how her husband blamed her for their child's ADHD and stated that since there is a

genetic link, "he obviously got it from your family because you are the stupid side of this

family!" This poor woman endured years of torment from her cruel spouse until she quite

recently divorced him.

Other mothers in the group discussed the "unsupportive" role of their husbands when it

comes to dealing with any child rearing problems. One of the mothers whose husband

was present also stated that her husband "does nothing," he does not respond to any problem, does not get involved in discipline or give any input whatsoever, nor does he assist with the children in any way. "Maybe, it is better being divorced and single than being married to this!" Obviously, these women were quite emotional about these sensitive issues and the lack of support from their husbands. Only one father commented, stating that the reason his wife is "so stressed out" is because she "constantly nags and shouts at the kids", "she should be the first to learn more about the disorder and how it affects the child before shouting".

Sibling issues – the conflicts in families with ADHD children are not confined to parent-child or parent-parent interactions, increased conflicts have been observed between ADHD children and their siblings (Mash & Johnston, 1983). When parents began the discussion on the conflicting interactions between the ADHD child and their siblings, the parents with only one child in the family stated that "this is one less stressor for me". The participants who had two ADHD children in their families appeared to be having it "toughest" as one parent stated. The families with two children felt that there was a "constant struggle between the two children to get the parent's attention". Others reported that the "normal child wants nothing to do with the ADHD child" which is a source of "embarrassment" to him/her. "My home with three children, one being ADHD, is like a "constant war zone" and I am "mediator" was the retort of one mother. Sometimes the other child feels like the parents "always favour the ADHD child" and "it's not fair".

Session one ended with giving participants homework on recognizing stress.

SESSION 2: EDUCATION ABOUT ADHD

OBJECTIVES:

- To correct any parental misperceptions about ADHD.

- To help parents generate realistic expectations of their child.

- To empower parents in discussing their child's difficulties and communicating their child's needs with others.

This session focused on providing parents with accurate information about:

- The history of ADHD.

- Presumed causes of ADHD.

- Core symptoms and associated difficulties of ADHD.

- Adolescent and adult outcomes.

- Treatment options for ADHD.

In this session, parents were encouraged to ask questions, were given a recommended reading list on ADHD, and were given handouts to help them inform others about ADHD.

Discussion

Several parents sighed in relief after the section on the causes of ADHD as there was now "proof that poor parenting is not a cause of ADHD." The respondents mentioned receiving several negative comments from others which implied they were to blame for their child's condition. "Spouses, siblings, family members and school staff" were identified by parents as blaming them for their child's behaviour. Some mothers implied blame from their husbands, for example, "There's nothing wrong with my child, you (the mother) are looking for a problem and you need to spend more quality time with the child".

One mother reported blaming herself for "being the worst parent on earth." She stated that "everybody else can do it and I can't, there must be something wrong with me." Another mother reported having neighbours "believe she was doing something to her child" as the child would "throw tantrums and scream so loudly, the neighbours in the flat would come to see if she was doing something to the child."

Most parents, mothers and fathers expressed a need to "acquire more knowledge" about their child's disorder. Parents believed that only through more knowledge about ADHD, could they "do something to help" their child. Two couples from the sample have attended counselling sessions with a psychologist in order to assist them "understand ADHD and to be able to deal with it." These parents believed that counselling helped them to "stop blaming each other and fighting each other" and rather to "unite and

support each other" in coping with their child's condition. Not surprisingly, in these

couples who attended counselling, both spouses participated in this programme.

One father stated that "just having knowledge on ADHD and being able to talk about his

son's condition to someone else is empowering by itself." Some parents stated that it is

also important to educate their ADHD child about his condition so that "he can avoid

certain problem situations."

This session ended with giving parents a reading list on ADHD and a handout on what

was covered in this session.

SESSION 3: RESOURCES

OBJECTIVES:

- Identification of community and educational resources.
- To reduce parents' frustrations in seeking assistance.

This session provided parents with a list of support groups for parents with ADHD

children and a list of special education services, that is, schools for children with specific

learning disabilities.

These support groups are run by professionals in the field and aim to provide

information, resources, support, advocacy, professional training, policy, etc. They offer

contact with other parents, access to information pertaining to ADHD, newsletters, information on parent support groups, seminars and access to community groups and interested professionals.

The specialised education institutions (schools) aim to support the educational development and social well-being of children with average intelligence, who have specific learning disabilities and problems in reading, writing and or maths.

Discussion

All parents agreed that they should belong to a support group for parents with ADHD children so as to "find out what's the latest news on this condition, to ask questions and get the answers, to hear other parents' experiences and to learn from them, to get people to listen to your problems and just to have support through the difficult times."

A significant concern for these parents was the issue of "where to send their child to school" as all participants reported that their ADHD children attended mainstream schools. Parents also discussed the possibility of " moving the child from a mainstream school to a "remedial school" as being perceived by the child as stressful" because "the child might think that there is something wrong with him, that he is stupid or retarded." Some parents also mentioned that it might be very difficult for their child to make new friends as "it took him forever to secure the one friend he has."

The fathers in the group felt that "it would be detrimental to move the child as some of these schools also catered for mentally and physically handicapped children" and "their ADHD child might start imitating the other kids' behaviours." Several mothers believed that "by placing their children in the appropriate institution which can only help their children by catering to their individual needs was far more important than being among children with bigger problems, that is, the mentally and physically handicapped children."

Both the divorced mothers stated that "these educational institutions are the ideal place for my child and it would save me some money because right now I pay separately for his occupational therapy sessions and his sessions with the psychologist, and what about his Ritalin, whereas, most of these schools have multi-disciplinary teams on their staff, including the therapists."

Others believed that "besides the financial saving, my child will also be getting the best services for his condition because lets face it, our government schools don't know how to deal with ADHD kids, the teachers are lost and the classes are far too big, our kids are lost in this system, they are recognized as "abnormal", not different, and are either pushed into a corner so as not to cause chaos and disturb others, or they are simply ignored."

One father was very upset by the fact that his child had been "promoted from grade one to grade two without any problems, then all of a sudden the flurry of complaints from his

teacher started pouring in: he's not concentrating, he constantly disturbs others, he does not complete his work, etc." The question he posed to the group was "why wasn't his child's problems picked up earlier because the child is in the same school as last year, why suddenly all the complaints?" He further stated that "teachers are not properly trained to recognise children's problems" and given that "ADHD is the buzzword these days don't you think every primary school teacher needs education/training and to attend workshops on this topic?" All parents agreed with this participant.

SESSION 4: PROBLEM-SOLVING SKILLS

OBJECTIVES:

- To enable parents to generate adaptive responses to stressful situations.
- To increase parents' sense of self-efficacy and control.

This session looked at how parents responded to problem situations when they are under stress and how they defined problem situations. Possible solutions were generated, by weighing the positives and negatives of each plan of action and then the best solution was decided upon. The chosen solution was then put into practice via role play and this was then evaluated by the participants in the group. The focal point of this session was for parents to learn these problem solving skills and practice using them so that it becomes automatic, thus enabling them to respond effectively even when the stress of a situation is clouding their thinking.

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Discussion

The major frustration for parents in this study was discipline. This is also reflected in Wender (2000), who states that the main problem of the ADHD child at home involves discipline. Parents stated that they "normally respond to problems by avoiding it (leaving the room), ignoring or tolerating a situation in the hope that it would go away, or doing nothing in the hope that the situation will improve by itself." They also stated that to date "none of these methods have worked permanently."

One parent stated that she "normally tries to avoid confronting problems with her ADHD child because it only results in a screaming contest and tears on all sides, from the child and myself." Another respondent replied that she "immediately confronts her child for telling lies about completing his homework when he hasn't and then I get a note from the teacher the next day to complain that he did not do his homework." "By this stage, I am so tired and angry, all I can do is lash out at my child and call him a liar, then the fighting starts, then he gets a terrible hiding."

One of the fathers in this group described how sometimes he "comes home from work after a really bad day and is totally stressed, only to find his wife and child screaming and arguing with each other." "What am I supposed to do? I can't take this any more, so I either go to the pub for a drink and some peace and quiet or I blow my top and scream and swear so loudly that everybody just shuts up!"

Some of the main problems experienced by these parents relates to:

- "Their ADHD child's inability to follow instructions"

- "Dealing with tantrums". According to Barkley (1998), although temper tantrums may be common for even normal children, however with ADHD children their frequency and intensity are often exacerbated.

- "Not understanding what was said to them"

- "Inability to think in a flexible manner, once they fixate on something, they must do it or have it."

- "Acting without thinking of the consequences of their actions."

Other group members agreed that they have "learned through experience with their ADHD child that they cannot stop the problems and change their child to be perfect but that they can change the way they respond to problems, so as not to make it worse." Participants in the group believed that they "needed some kind of strategy or plan to follow when dealing with problems and this session provided them with that tool". All agreed that "the success of this session can only be evaluated after they go back to their families and put the steps of the problem solving skills that were taught tonight, into action."

SESSION 5: COGNITIVE RESTRUCTURING

OBJECTIVES

- To help parents develop more realistic expectations of their children and themselves.

- To reduce emotional arousal when expectations are not met.

- To reduce the negative impact of unhelpful comments from others.

In session 5 parents were taught the link between thoughts, behaviours, and emotions. Common cognitive errors were identified and their effects on emotions and behaviour were discussed. Parents identified and challenged their own faulty cognitions and began the process of replacing them with more adaptive thoughts.

Discussion

All parents agreed that "the manner in which they think about a situation, determines their feelings and behaviours about the situation." What was evident in this discussion is that "mothers and fathers generally perceived events or situations very differently." Fathers stated that the "mothers think too much and almost always blow things out of proportion, only making the situation even worse." Mothers, on the other hand, believed that "fathers don't respond appropriately enough when something happens."

One typical example that illustrates the point of how the way one thinks about a situation can affect their feelings and behaviours was provided by one of the parents in this group.

She told the group how "every time the telephone rings during the day, she immediately thinks the worst, that is, that her child has got into trouble at school, and starts to feel stressed. However, if the telephone rings during the evening, it does not bother her particularly." From this example, it is evident that it is not the situation (the telephone ringing) that causes the parent to feel stressed, but rather her thoughts about the situation (that something has gone wrong with her child at school) that causes her to feel stressed. One parent commented that during this session we discussed "common errors in thinking", such as filtering, where we tend to focus on the negative and filter out all the positives. For him, it was difficult to change his mindset regarding his ADHD child because as he stated, "the negatives outnumber the positives."

Most parents agreed that they "were guilty of most of the common errors of thinking mentioned in this session and maybe that is why they are so stressed by their interactions with their ADHD child." Parents also mentioned "that self-coping statements will definitely help them in the future to recognise and challenge their negative thinking."

SESSION 6: COMMUNICATION SKILLS

OBJECTIVES:

- By improving communication skills, it would facilitate child compliance and positive parent-child interactions.
- To increase parents meeting one another's needs.

- To be able to identify child's needs and address these needs by appropriate professionals.

This session focused on identifying dysfunctional patterns of communication between parents and their ADHD children, spouses/partners, extended family, and health and education professionals. Session six also focused on: communicating effectively with children, giving effective commands, communicating effectively with others, communicating difficulties to others, and listening to others.

Discussion

Parents really appreciated this session as they believed that "communication was one of the biggest problems with ADHD children, partners, family, school, work, etc." Most parents experienced the following difficulties communicating to their ADHD child:

- "Child won't listen."

- "Child doesn't do as he is told."

- "Child doesn't always understand what he has been asked to do."

Many parents acknowledged communicating with their child when they did not have the child's full attention, e.g. while they are watching television or playing a computer game. Some parents presented "commands as questions or favours." Most parents in this sample stated that they "often forgot to comment positively on their child's behaviour when he has followed instructions and completed a task."

One of the fathers in this group stated that one of the reasons his child does not listen to his mother or follow her instructions is because" she is always threatening to whack him if he doesn't listen and to date the child knows he has never listened to her not once, nor has she whacked him, not even once!" Another mother stated that her husband "never listened to her when she tried explaining to him what she's going through with their child, even if he listened, he never responded, he would just continue staring at the television!" Often this would be the start of a huge argument between them because the mother felt that she was being "ignored" and the father would defend himself by saying "I thought you just wanted me to listen, I didn't know I had to respond!"

SESSION 7: SELF-CARE SKILLS

OBJECTIVES

- To teach parents how self-care can reduce stress.
- Introduce time-management and relaxation techniques aimed to help reduce psychological and emotional arousal when experiencing stress.

Session 7 addressed the importance of self-care skills in reducing stress for parents with ADHD children. Both, time management skills and relaxation techniques were introduced and practiced in the session. Parents were encouraged to establish a balance between the competing demands of children, partners, work, and their own needs. The following topics were covered in his session:

- Time management

- Pleasant evening scheduling

- Relaxation

- Nutrition

- Exercise

- Sleep

Discussion

Most parents agreed that when it came to self-care, they "often neglected" this component of their lives. The mothers in the group stated that "between caring for the kids, the housework, the demands of their job and family, there was no time for themselves." The unemployed mothers agreed that their "best time is when the kids are at school and the house is empty, because that is the only time to ourselves."

None of the participants in this group stated creating any schedule in order to manage their time more effectively, as one mother put it as follows, "In my life there is no such thing as time management, something is always happening and I need to respond immediately. I don't have certain hours for certain activities and there is no such thing as "me" time!" Another participant stated that she was guilty of "trying to do everything at once, by myself while my child is at school, without prioritizing, and this often leads to me feeling exhausted and stressed."

Two of the fathers mentioned going jogging at least twice a week for half an hour to "de-stress". None of the mothers in the group exercised and one mother stated, "I don't need to exercise because with my child, I am constantly on the go, eat when I get a chance, often skipping meals, and fall into bed after every exhausting day and sleep as though I'm dead." Roger Fillingim and James Blumenthal (in Lehrer & Woolfolk, 1993) describe the use of exercise as a stress management tool. The beneficial psychological effects of exercise have been highly touted in the popular media and among physical fitness proponents for many years. Recently, an increasing number of empirical studies have begun to document the significant effects of exercise on reducing stress reactivity.

Three of the parents used prayer and meditation as a form of relaxation as this was their "only quiet time away from their children." These parents had temples built outside their homes so it was away from the rest of the family, "a quiet and peaceful place to reconnect and recharge our batteries for what lies ahead." According to the available literature on stress management techniques, Yoga has been an integral feature of the Hindu culture for over 2000 years. Elements of that tradition, especially meditation, recently have been appropriated by western therapists in their efforts to find more effective tools to combat tension and stress (Lehrer & Woolfolk, 1993). Several studies indicate the therapeutic potential of Eastern forms of meditation to produce decrements in physiological arousal (Woolfolk, 1975 in Woolfolk & Lehrer, 1993) and improvement in stress-related disturbances (Shapiro & Giber, 1978 in Lehrer & Woolfolk, 1993).

None of the participants in this group ever scheduled any pleasant events. Parents described their lives as being "so rushed and hurried, we don't even have the time to soak in a relaxing tub filled with Radox, those are luxuries that we don't have time for. We just jump in and out of the shower."

Finally, participants were reminded that there are several different methods of relaxation techniques and they need to choose what works best for them, such as:

- Progressive Muscle Relaxation which involves tensing and releasing the muscles in the different parts of the body.

- Release only Relaxation which is similar to progressive muscle relaxation, but does not involve tensing.

- Body Scanning. This involves directing your attention to various areas of the body in search of tension. The idea is to imagine various parts of your body and check them for tension, then, apply relaxation skills to relieve the tension in those areas.

- Visualisation involves relaxing your body, clearing your mind of distractions, and imagining/visualizing pleasant, relaxing scenes (e.g. a tropical island, a cool forest, a clear stream).

- Massage.

- A warm bath/shower.

- Reading a book.

SESSION 8: PARENTING SKILLS

OBJECTIVES

- To increase parents' awareness of punitive parenting practices.

- To help parents use the skills already taught to deal more appropriately with their child's difficult behaviours.

This session briefly reviewed the use of behaviour management techniques with children and adolescents, in particular, the appropriate use of discipline. Behaviour management techniques for use with children under eight years of age were discussed and information was provided about the following:

- Attending

- Decreasing disruptive behaviour

- Token system of rewarding good behaviour

- Negative consequences for poor behaviour

- Time out

Suggestions for effective behaviour management with older children and adolescents was also discussed and included:

- Understanding adolescent development and the impact of ADHD

- Developing realistic expectations

- Establishing household rules

- Monitoring and enforcing rules

- Communicating with teenagers

- Problem solving

Several good self-help books were recommended for parents to read which offer more information on behaviour management techniques. The section on older children and adolescents was included in the programme, although all the ADHD children in this sample of participants were under 10 years of age, because parents needed to be equipped to deal with the near future regarding discipline.

Discussion

All the parents in this sample agreed that they "were guilty of skipping straight to punishing their children, of not having any consistency in their disciplining techniques and not providing any incentives for good behaviour from their children." Several mothers explained that "there are hardly ever any good behaviours to tune in on" and therefore, they "cannot give the child positive feedback and warmth."

One father stated that "compared to all the bad, terrible things his son does on a daily basis, any good behaviour from him is like one single drop in the whole big ocean and it is not even worth praising him for because in the next two seconds he goes and does something even worse."

Several parents explained that they never arrange "special time" between them and their ADHD child, in fact they try to spend as little time alone with the child as possible. One mother stated that when her child is at home, "he's constantly in my face, he gives me no space and if I'm on the telephone or away from him for two minutes, he goes and does something terrible, so I have to stop what I am doing and attend to what he's done." The parents reflected on this and then agreed that "maybe that's one of the reasons why their child behaves so badly, so often, because when he's getting a shouting at for his bad behaviour, he's getting our attention, even if it is negative." The parents promised each other in the group to change this immediately and watch its effect on the child.

One of the mothers mentioned always comparing her ADHD child with his brother and always telling her child when he's done something wrong, "Why can't you be like your brother, I could have ten of him, but you, you are impossible!" Another couple stated that with their child, nothing works for too long. They have tried rewarding positive behaviours by buying him something he really wants, but "after a while, he falls back into being bad again and if we threaten to take away what we got him, he doesn't care because by that time he's bored of it!"

Parents mentioned smacking their children, shouting at them, locking them up in the bathroom, but that none of these methods really worked and the child now knows what to expect and also knows that it is only temporary. Parents stated that discipline is one of their biggest problems when it comes to parenting an ADHD child because " what works

with other normal kids don't work with these kids, they have no fear, and don't care about the consequences of their actions, or how it affects others."

The other important topic that was discussed by the respondents was consistency among both parents in the two-parent families. One of the mothers complained that when "she tries disciplining her child, her husband always undermines her in front of their child and accuses her of being too hard on him." "After this has happened a few times, my son now does not listen to me and prefers being with his dad as the dad covers up his bad behaviour or overlooks it."

The husband was part of this group and responded by saying, "My wife constantly nags and lectures our child, even half an hour down the line she's still nagging him about him not doing something earlier. She does not deal with discipline in an effective and appropriate manner and I believe this session will hopefully help her change her ways first before approaching the child!"

SESSION 9: WRAP-UP SESSION

OBJECTIVES:

- To complete the discussion of parenting skills
- To review the material covered so far in all eight sessions
- To answer any remaining questions

- To give each parent an appreciative inquiry questionnaire and set up interviews with their ADHD child.

The facilitator reviewed all the sessions and topics that were covered during the past eight weeks. Parents were asked to think about how they conceptualized stress when they first started the programme, how they recognized stress, how they coped with it and how they believed it affected others around them. They were now asked to do the same thing in this session.

Discussion

Every one of the participants stated that when they first started this programme, their individual stress levels were so high that they believed nothing would help and they did not realize how stress affected themselves and others in their lives. Over the weeks they mentioned that it became easier to recognize a stressful situation, and to respond more appropriately to it.

They also mentioned that they never realized that their thinking affected their reactions to a situation, but now they know it's true. Parents mentioned that by practicing the relaxation techniques, their minds were clearer, they were communicating more effectively, thinking more rationally and solving problems and parenting more effectively. Several parents spoke specifically about the problem-solving and communication skills sessions stating that these two sessions have actually changed their

lives and has made it a better place to be. Not only are they happier with their child, but also with their partners, and work colleagues.

Before terminating, parents got together and told the facilitator that the group experience has been so positive and supportive to them that they have now decided to continue meeting as a parent support group once a week at their homes and invited the researcher to attend if possible. The researcher thanked them and wished them the best of luck with the group and offered them her services if ever needed.

4.5 APPRECIATIVE INQUIRY ANALYSIS

As already stated in chapter 3, the model that was used for the appreciative inquiry approach was the Four-D Model (refer to Figure 2), which includes the following processes:

Discovery: Appreciating what gives life. The goal of the discovery phase is to appreciate the best of **"what is"** by focusing on peak moments of excellence. This is a time when people have experienced feeling most alive and effective (Watkins & Mohr, 2001). Participants identify and learn from even the smallest examples of success while focusing on what gives life and energy.

Dream: Envisioning impact – **"What might be"**. The dream phase encourages participants to challenge the status quo by envisioning a preferred future (Watkins & Mohr, 2001).

Design: Co-constructing the future – **"What should be."** Participants craft provocative propositions, which bridge the best of what is with one's own speculation or intuition of what might/should be, during this phase (Watkins & Mohr, 2001).

Delivery: Developing a plan for implementation – **"What can be."**

By employing an appreciative inquiry model to evaluate the stress management programme for parents with ADHD children, the positive aspects of the programme were examined, and ways of improving it were recommended, in order to create a more effective community intervention.

In the questionnaire, the first question: "Describe your experience of the programme" required respondents to explain their feelings, observations, acquisition of skills and knowledge and growth as individuals as a result of participating in this programme (Discovery Phase).

The second question in the questionnaire: "What do you appreciate about the programme?" pertained to respondents reflecting on the strengths of the programme, the positive aspects of it (Dream Phase).

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The third question: "How can this programme be improved?" This question focuses on positive growth for the future use of the parent stress management programme (Design Phase).

4.5.1 KEY THEMES: PARENTS' RESPONSES

Upon close examination of the qualitative data which were given as answers to the three questions on the appreciative inquiry questionnaire, statements with similar, though not identical, meaning were gathered into categories. To enhance interpretation, key phrases were included. The following key themes emerged:

a) Empowerment

All participants in this study acknowledged the importance of the education and knowledge component of the programme. They believed it helped them feel "less guilty" for their child's condition because they now know what actually causes ADHD and what does not cause ADHD. This in turn helped them to have more realistic expectations for their children with ADHD. By better understanding their children's behaviour, they changed the way they approached and perceived problem situations. They began to understand that their children's behaviours are not always purposeful, and this has by itself helped them to avoid dealing with problems in a negative manner, thereby reducing their stress. They have learned to acquire, through practice, from the programme, the appropriate skills so as to enhance their relationship with their ADHD child.

All parents also mentioned that before participating in this parent stress management programme, they tried to understand the disorder by "reading up on available literature, in order to feel empowered and to be successful as parents," however, parents stated that they now feel that they "have adequate knowledge and skills not only to be successful parents to their ADHD children, but also to help other families in this same predicament." Parents believed that the knowledge and skills which they have acquired through this programme, via the content covered in the sessions and, by belonging to a group of parents who "you can talk to about your child's ADHD because they are experiencing similar problems", has made them feel "empowered and confident, not only in themselves, but in all situations, be it in their home, dealing with others, even at work."

- *"Participating in this programme was the most incredible thing I've ever done and it's changed my whole outlook about my child, I can finally say that I understand him."*

- *"The skills that I have gained from this programme will definitely help me deal with life and my child in a better manner. Even my husband agrees that ever since I began participating in this programme, I'm easier to approach, calmer, I handle difficult situations with my son and others differently, resulting in positive outcomes."*

- *"For the longest time now, I have totally neglected myself because I felt guilty being away from my ADHD child or not doing something relating to him. Everything, my whole world, had to revolve around him. By participating in this programme, I have learned that with proper time management, I can make time*

for everything, including myself, and the best part is that I don't have to feel guilty about it. I now feel like I am living again."

- *"I think it's made me stronger as an advocate and as a parent. I feel more comfortable talking about things that I'm dealing with that might be really upsetting at the time."*

- *"I feel more comfortable talking to the participants in the group than I do to others because I know nobody judges you or your family circumstances here because you are all in the same boat. By talking about stuff, I feel better, calmer. With these sessions, I now feel confident enough that things are going to improve for us (my family) because I have already seen some slight positive changes since starting the programme. Thank God for that because I was ready to throw in the towel."*

- *"I have actually arranged for my wife and I to give a talk at my son's school on ADHD and how it affects the child. I feel this is the right thing to do and that we are equipped with the knowledge and skills acquired from participating in this programme. This will definitely help the school personnel understand my child better."*

- *"As a father, it was very difficult for me to accept that there was something wrong with my child. Today, I feel thank God I know what it is and how to deal with it. My biggest challenge came during the third week of this programme when I had to explain to my boss that I had to leave early to attend this programme, what it's about, why, etc. Having the necessary information on ADHD and being able to*

explain to somebody else really made me feel liberated and empowered for the

first time since my son was diagnosed with ADHD."

- *"I feel good knowing that I have so much of knowledge on ADHD and the*

  necessary skills to deal with it, such as effective disciplining, dealing with my

  stress in a better manner, and to be a little more patient when dealing with

  problems."

b) Group Cohesion

Through this programme, parents gained increased skills, an increased sense of power and a sense of belonging. Participants were able to connect with each other and provided support and skills to deal with the day-to-day issues of raising a child with ADHD. Participants described the group as a place where everything they were experiencing with their child with ADHD was accepted and understood. The group was perceived as being an open place where participants could express their feelings about living with a child who has ADHD and receive support to help them learn to solve any problems that they encountered. Participants' experiences of being a member of this group were viewed as extremely positive.

- *"I definitely appreciated the group sessions instead of individual sessions because*

  I was able to learn not only from the facilitator, but also from the others in the

  group and some of the information I received from other group members was very

  useful."

- *"For me, I felt inspired by seeing other role models in the group who have been where I was, feeling defeated and hopeless, and now seeing them winning this endless battle with ADHD, gives me hope that things can get better."*

- *"By talking with people in similar situations, it fosters a sense of belonging and promotes hope for me."*

- *"A great burden was lifted from my shoulders when I was able to express my feelings without shame in front of others in the group and in the presence of the facilitator. It was a safe, understanding, and supportive environment to express your deepest fears and worries.'*

- *"I felt so much better when I had some advice or assistance to give another group member so as to help them. The fact that I could help somebody else made me feel helped in a way."*

- *"I don't feel alone anymore because people are going through similar things that I am, or they have been there."*

- *"Because others in the group have experienced similar problems as me, this shared experience provides us with a sense of partnership in dealing with issues of children with ADHD. This group was an excellent source of practical information for me.*

- *"Eventually the group felt like members of my family, we share a common bond so when we are together my problems just don't seem so huge anymore. I have made many friends in this group whom I intend to continue meeting with even after the programme is terminated."*

The aim of group counselling is to get closer to participants' understandings of and perspectives on certain issues (Breakwell, Hammond, & Fife-Schaw, 1998). The group is by definition an exercise in group dynamics and the conduct of the group, as well as interpretation of results obtained must be understood within the context of group interaction (Stewart & Shamdasani, 1990:7 in Breakwell, et al., 1998). Two interrelated forms of evidence are therefore derived from groups: the group process (the way in which people interact and communicate with each other) and the content around which the group process is organized (the focal stimulus and the issues arising from it).

c) Role of Facilitator

The role and skills of the facilitator are fundamental to the effectiveness of the group (Breakwell et al., 1998). Whilst the facilitator encouraged an environment of trust, empathy, caring, warmth, understanding, and sensitivity to respondents' experiences and feelings, she had to intervene at times during a group discussion in order to maintain the productivity of the group. For example, when two members of the group, (a husband and wife couple) were engaged in a heated argument at the expense of others in the group who were obviously experiencing discomfort, the facilitator had to take the necessary steps to defuse the situation, refocus the group and balance out the discussion process.

- *"The group facilitator was a kind, understanding, and warm person so I felt comfortable enough to discuss personal issues in her presence."*

- *"Initially I was a bit sceptical about the group leader because she mentioned not parenting a child with ADHD and I thought how could she possibly understand what we were going through. After the initial session my fears were put to rest as I realized she was very interested in our personal experiences and she was very knowledgeable, experienced, and skilled as a psychologist who had treated many kids with ADHD and had some understanding of what their families go through. She was our captain who steered our boat across stormy seas to bring us back to dry land."*

- *"The approach of our leader was very important in this parent stress management programme. It was her initiative and assistance that helped get us to where we are now, which is definitely a far better place than where we had been when we started this programme, and for that I thank her."*

- *"Our group facilitator created the perfect environment for our group. She accepted our differences, she never judged us, she placed no pressure on us to speak, she always listened to every one of our stories whether they pertained to the current session or not, she always emphasized the confidentiality issue, and she made us feel comfortable and responsible for the group."*

- *"I loved the way the psychologist paid attention to me when I spoke in the group, as if her whole body was attending to what I was saying, always confirming what I had stated, questioning for further clarification and always responding in that voice that tells you that "everything is going to be better". I put my faith in her and she has not let me down. Today, I am a better person and mother and it's all thanks to her."*

- *"Although what we were going through was serious and hectic, when we were with her (psychologist), we felt empowered and in control. I don't know if it is some kind of vibe that she gives off or whether it's her aura but just being around her and listening to her speak makes me feel better and calmer."*

- *"I appreciated her honesty and the fact that she would speak openly about her child to us. It made me realize that although her child does not have ADHD, she still has other problems and even though the group leader is a psychologist, she is also a mum and also experiences her fair share of parenting issues with her child. It helped me accept her into the group and I felt I could relate to her as a parent instead of a professional only."*

- *"It was difficult for me to relate to the facilitator in the beginning because I am a man and she is a woman who might not see things the way I do. Not once did she do this, I felt extremely comfortable and understood by her. She is very caring and easy to talk to. She has no airs and graces about herself although she is the professional, she can come down to our level and this is one of the reasons our group was so successful, we never felt undermined or judged by her."*

d) Cognitive Restructuring and Behaviour Modification

The whole focus of this programme was to get parents to identify maladaptive patterns of thoughts and behaviours and to replace them with more appropriate ones learned from the programme. The key to doing this was for each participant to think about how their thoughts about a situation or event will influence how they feel and behave. This sounds

easier said than done because people are so accustomed to thinking and   behaving   in certain patterns that it is difficult to undo them quickly, and it is more difficult when these thoughts are negative. However, participants in this programme were encouraged, on a weekly basis to practice this at home with their families and friends. Parents reported several positive changes as s result of recognizing that some of their thoughts were inappropriate with no proof for existing. These thoughts were successfully challenged by parents and resulted in positive behaviour changes as illustrated by the following comments:

- "The first thing that I changed was thinking of my child as ADHD, he is not ADHD, he has ADHD, it is a condition, it's not him. By doing this I managed to separate the diagnosis from my child, the bad behaviours from him, the rudeness from him, etc. and I began to love him and accept him again and became passionate that together he and I can fight this condition."

- *"By changing the way I always think about my child as being wrong, the causer of problems and uncontrollable, I changed the way I dealt with problem situations in our home. I started understanding him, listening to what he has to say and giving him a fair chance. This changed the way he responded and made the situation easier to resolve. Nowadays, we handle each problem as if it is new and unique, we have no pre-conceived ideas of who did what and who is always wrong, and this has made things so much easier and more peaceful at home."*

- *"Not only have I changed my interactions with my child to a more positive note, I have also managed to improve my relationship with my husband. I no longer*

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think of him as a dispassionate man who fights me all the time. We have started communicating properly for the first time since our son has been diagnosed with ADHD, and it has made the world of difference. I feel supported and relaxed in my roles as mother and wife and I know if something goes wrong, I can deal with it and I have my husband to help me."

- *"After participating in this programme I started really thinking about what I think about things when it comes to my child who has ADHD and I have realized that everything related to my son and his condition was perceived in a very negative way by me. So, naturally I was stressed in my dealings with him, and this in turn stressed him out and this cycle continued until now. Now I have broken the vicious cycle, I am calmer, more understanding, I have more knowledge and skills to deal with stuff and I feel I have become a better mother. I am stronger, more in control and more empowered, and this created a safer environment for my child. He listens and trusts me now and yes, we still have problems, but not to the point of me wanting to run away from things because it's too much."*

- *"For the first time in a long time, I'm feeling in control of my life again. I feel good and everything around me is looking more positive. I stopped jumping to conclusions, I calmly approach problems with my child and I make use of all the things I have been taught in this programme and let me tell you, it works."*

- *"Not only have I noticed the improvements in me, my friends and family members have mentioned it too. They say I'm fun to be with, my communication skills have definitely improved and I am no longer edgy and stressed."*

- *"It's so true what we learned in this programme, that the way we think about something determines the way we will feel and respond to it. For the past nine weeks of the programme, I have decided to change my negative thoughts to positive ones and to cope with stressful situations in a better manner, to think about things properly before diving into it, and you would not believe the world of difference it has made to my family life. The kids say mum's back and even my husband appreciates me more. My child who has ADHD, is somehow easier these days, is it me or is it him because of the better me?"*

- *"I am so into breathing and meditation these days that, I have actually joined a Yoga class and it has definitely helped me deal with stress and it's my "me-time". I am no longer stressed by the unknown, I have learned tons in this programme, I feel it was designed especially for me, and I know what to expect from my child but also, I know that I have support and the necessary skills to cope with it. I know this programme has only been nine weeks long but I already feel such a positive change in myself. I know a lot of it has to do with my more positive outlook on things and I also know that my parenting skills have improved and home life is going to be fine from now on."*

f) Change as a Parent and as a Person

A common theme running through parents' experiences of this parent stress management programme is the idea of change. This reflects the idea that people are constantly changing in response to changing situations. Not only did the participants in this

programme experience change, so too did the facilitator, develop and change due to her experiences with the participants and the programme. The researcher played an active role in becoming a change agent by informing, encouraging and supporting the group, and studying and interpreting their actions in the light of interventions. This point is nicely captured in Breakwell et al., 1998, which states that the researcher's role as an agent of social change is that they are still a researcher, but a fully participating one.

- *"The experiences of this programme have helped me become more assertive in my role as a parent and as a person."*

- *"I now feel really empowered and have come to appreciate myself and all my abilities in dealing with my child's condition. I believe that I have come a long way and I deserve recognition for that."*

- *"As a participant in this group, I have learnt a lot and I am now more confident and far more outgoing. I am stronger and tougher."*

- *"I have learnt to believe in myself and that nobody knows more about my child than I do and this empowers me."*

- *"This programme has made me look at life differently. Things can be fixed and get better. This is not the end. I can make a difference to my child's life and my life. I have the power to do that.'*

- *"It was high time that I got my act together. If I can't stand up and help my child, nobody is going to."*

- *"I have totally accepted the diagnosis my child has of ADHD, I am doing everything I can to learn everything there is to know about ADHD in order to*

support and assist my child. I cant' give up because if I do then what happens to

the child!"

- *"I was always blamed for our child's condition and felt maybe it really was my*

  fault. Today, I can say that I am not to blame, there is nothing wrong with me. I

  may not be a perfect parent but who is? No longer do I care about how untidy the

  house is or where will I find the time to do this or that, I concentrate on the

  important things, I prioritise and I tell my child everyday how much I love him."

4.5.2 RESPONSES OF PSYCHOLOGIST

Since the first psychologist responded on the original version of this programme, psychologist two filled in an appreciative inquiry questionnaire on the current adapted stress management programme as it was administered to this sample of parents. Psychologist two was also given a copy of the study as it was conducted in New Zealand, including the original programme and its results. The psychologist's responses follow:

- **Effective** — *"The parent stress management programme appears to prove effective for mothers and fathers of children with ADHD."*

- **Comprehensive** — *"This programme should be included in the comprehensive management of ADHD. It is easy to understand and user friendly as it involves working directly from the treatment manual."*

- **Adaptability** – *"Although the group format may not be appropriate for all parents, the sessions can be adapted for use with individuals."*

- **Quality** – *"It's nice to read a study that is not bogged down with quantitative measuring instruments and stats. I really enjoyed the qualitative aspect of your approach, to me that is where the real quality lies."*

- **Flexibility** – *"As we discussed, the nice part about this stress management programme is that it is so flexible and comprehensive that it can easily be evaluated either from a qualitative approach (like you have done) or, quantitatively, like the psychologists in New Zealand have done."*

4.5.3 CHILDREN'S RESPONSES OF OBSERVED BEHAVIOUR CHANGES IN PARENTS

As mentioned earlier, after termination of the programme, parents were requested to set up an appointment to have their child with ADHD interviewed briefly by the researcher. This method provided a means for the researcher to confirm parents' responses in the appreciative inquiry questionnaire. The children were asked only one question: **"You do know that your mum and dad/mum only has been attending a parent programme for several weeks now. Have you noticed any changes in them, or the way they now interact/respond to you? Can you please tell me about them?"**

All the children that were interviewed commented on the following improvements:

Relaxed

- *"I love my mummy the way she is now, she's calmer and more relaxed. Her headaches have stopped and she's not taking any more pills. She used to shout a lot at me and dad but now she's better. I hope she still comes to you."*

- *"My dad doesn't work so much any more. His face is not cross all the time now, he smiles and he's calm with everybody, even the garden boy. He started playing with me again and I'm very happy."*

- *"Now when I make naughty, mum and dad go to their room first and then come out together to deal with me. It's okay because I stopped getting a hiding. We all play and watch T.V. together. The other day, dad and I went fishing on our own and it was so cool."*

- *"I can talk to mummy now without us fighting, she's more understanding and has stopped shouting at me for everything. Did you give her some pills to be calm? Can I have some for later, in case she starts getting cross again, I can give her the pills?"*

Approachable

- *"Before, when I used to do something wrong, or get into trouble for something I would never tell my mum because she would make it worse. She would shout at me and make me cry, even when it wasn't my fault. Now, she speaks to me nicely and I feel I can tell her stuff."*

- *"One day I even pee-ed in my pants I was so scared when I dropped the glass vase, I knew I was going to get a hiding and I did. Now, its okay, my parents say: everybody has accidents, it's not the end of the world but try to be a little more careful."*

Loving

- *"I always thought that I was adopted because I was different from my brothers and I knew that my parents didn't love me. These days I think they love me more than the others."*

- *"My mum now tells me everyday that she loves me."*

- *"I get to have special time with my mum, our special time and I feel so happy then, and I promise you I am very good now."*

- *"I feel bad to do naughty stuff now because we are all getting along so nicely, me and mum and dad and I don't want to spoil it."*

Included

- *"Now they care about me, they do stuff with me."*

- *"When I used to laugh loudly for nothing, mum used to get cross with me, now she also starts laughing with me."*

- *"We now have new rules at home which we all made together, me too, because I am also in this family, dad said that and we must follow the rules."*

4.5.4 SUGGESTIONS FOR IMPROVEMENT

All participants believed that the parent stress management programme was a huge success for them. The psychologist who filled in the appreciative inquiry questionnaire and the parents believed that the following suggestions for improvement could only enhance this programme:

a) Separate groups for mothers and fathers

Three couples participated in this programme and there were times when issues were becoming quite sensitive and personal and they began attacking each other verbally and this made other members feel discomfort. Also, the psychologist believed that having husbands and wives in the same group could cause friction and this could be transferred to the home situation.

- *"Men and women see things differently and should have been put into separate groups, especially no husbands and wives in the same group because they only argue and blame each other."*

- *"Maybe if the facilitator was a man, different aspects would have been discussed. It is better to have separate groups for mothers and fathers and for the facilitator to be of the same gender as the group members."*

- *"There were times when I couldn't say what I really wanted because it pertained to my husband and he was in the group, it would have been better if the group was for mothers only."*

- *"In the one session I mentioned how my wife nags, nags, nags, maybe this was insensitive of me to do this in front of others because when we went home she was most upset and refused to speak to me. I had to explain to her that the whole purpose of this programme is to be honest with each other. I feel we should have separate sessions for mothers and fathers."*

b) Inclusion of a session with ADHD Child

Participants were of the opinion that since the focus of this intervention is based on their interactions with their child with ADHD, then, maybe a session or two could have been devoted to observing their interactions with their children. They strongly agree that the children should have been included in at least one session.

- *"Perhaps if the facilitator had an opportunity to see exactly how we interact with our children, she would get a better idea of what goes on in our homes. It would have been nice to include the child aspect in at least one session."*

- *"I know we role-played scenarios depicting negative interactions with our children with ADHD, but I think it's different when it's with somebody pretending to be the child, rather than the child itself."*

- *"There should be more parent-child activities in the programme and our children should be included in the programme because that is where the problems stem from, from our interactions with them."*

- *"By adding the child dynamic as part of the programme, the researcher would be able to understand how the negative interactions play out in the home front."*

c) Funding for Childcare

Several participants were of the opinion that more parents would have participated in this programme had the researcher provided funding for childcare. Participants also stated that they found it financially taxing to pay a baby-sitter for minding their children for the duration of the programme and monetary allowances for this purpose need to be included in future programmes.

- *"I didn't mind paying somebody to watch over my kids whilst I attended this programme but I know of several parents who were keen to participate but could not afford a baby-sitter because of financial constraints."*

- *"I am sure that the researcher could have made a plan to secure funds for childcare for the participants from her university's research department funds because it was costly for us to be here and this needs to be considered in future programmes with parents."*

- *"No family members are willing to mind my child if I am busy so I had to find a baby-sitter (a student) who charged me R50-00 per evening and I had to prepare a meal for her as well. Also, my son doesn't like being left with strangers, it makes him nervous and he clings to me on my return. These are issues that need to be considered when planning a programme of this nature for parents."*

d) More Sessions

All parents agreed that there should be more sessions, of longer duration and run on Saturdays instead of a weekday evening.

- *"Because there are eight of us, we feel rushed to give everybody a chance within our two-hour session. Sessions should either be longer or, there should definitely be more sessions."*

- *"Some sessions could have included a talk by a doctor to discuss specifics such as medication and answer some related questions."*

- *"More parent time, to talk and get support from each other. Definitely more sessions."*

- *"If possible, the programme should have been run like this: one group for mothers only, one for fathers only and one for parents and their child/children with ADHD. Obviously, you would need more than one facilitator. I loved the sessions and hope the facilitator will run more of them in the future. I will definitely attend again and tell other parents about it."*

e) Including the School Component

Parents expressed the need to have more information, knowledge and skills on how to deal with their child's school personnel. They believe that this important component should be included in this programme as interactions with their child's school personnel were also identified as extremely stress provoking to these parents.

- *"I believe that programmes similar to these need to be implemented in schools because the school and the teacher are also important aspects of my child's life."*
- *"Teachers lack the knowledge and skills to understand my child and his condition, maybe, a session should be dedicated to include either the child's teacher or ways for parents to interact with the teacher."*
- *"The school component is definitely missing in this programme.*
- *"The programme should devote some time to the ADHD child and school."*

4.6 CONCLUSION

Chapter four engaged in a detailed discussion of a session-by-session analysis of the parent stress management programme. Qualitative data from the appreciative inquiry questions and the children's responses from the interview were examined for key themes. This was followed by a discussion of the results under these themes. The following chapter, chapter 5, discusses the recommendations and possible avenues for future research studies.

CHAPTER 5

RECOMMENDATIONS, LIMITATIONS AND IMPLICATIONS

5.1 INTRODUCTION

The purpose of this study was to evaluate parents' experiences of participating in the Parent Stress Management Programme for Parents of Children with ADHD. If the programme is effective in treating and managing parenting stress of the participants then it is hypothesized that the relationship between parent-child interactions would improve, resulting in more positive child-behaviours. This was investigated by using appreciative inquiry and process evaluation techniques. The critical questions that guided this research were:

- "Describe your experience of the programme" required respondents to explain their feelings, observations, acquisition of skills and knowledge and growth as individuals as a result of participating in this programme (Discovery Phase).

- "What do you appreciate about the programme?" pertained to respondents reflecting on the strengths of the programme, the positive aspects of it (Dream Phase).

- "How can this programme be improved?" This question focuses on positive growth for the future use of the parent stress management programme (Design Phase).

Chapter four presented a detailed discussion on the results yielded by the research data. The methodology utilised for this study allowed a rich and in-depth view of parents' feelings, beliefs and opinions of their experiences of participating in this programme. This data was qualitatively analysed, with the main themes being identified and discussed. In this chapter, a general summary of the findings, the limitations and the implications of the study, and avenues for further research are discussed.

5.2 SUMMARY OF FINDINGS

The Parent Stress Management Programme for Parents of Children with ADHD was evaluated using the following techniques:

Face Validity of Instrument

Psychologist 1: Psychologist 1 evaluated the original format of the Parent Stress Management programme as it was administered in New Zealand. Thereafter, based on her opinions and views and with further discussions, the researcher adapted the original programme for use in this study (see chapter 4). Psychologist one's responses served

more as a measure of Face Validity of the programme, that is, to measure the relevance of the programme to the phenomenon being measured.

Process Evaluation

To evaluate the extent to which the programme was implemented as planned and to describe the subjective views and experiences of participants' process evaluation techniques were employed. This was done by a session-by-session evaluation in the form of a group discussion after every session. As already noted in chapter three, the aim of this process was to improve the quality and efficiency of programme operations by understanding the internal dynamics of the operations.

The Parent Stress Management Programme was implemented according to the guidelines in the manual. The format was strictly adhered to for all nine sessions except the content for session three on Resources that had to be adapted for our local South African population (as noted earlier, this programme was developed and implemented in New Zealand). No problems were encountered in the administration of this programme. The participants found the content easy to understand, relevant and extremely helpful. The discussions held at the end of each session confirmed these findings and suggest that the programme was effective by improving parenting stress, parenting skills, parenting styles, and interactions of these parents with their ADHD children.

Appreciative Inquiry

The appreciative inquiry analysis describes the subjective views and experiences of participants.

Parents commented on the empowering effect that this programme has had on their lives. They also commented on the positive outcomes of the programme in creating cognitive (the way they thought about situations or events) and behavioural changes which resulted in positive thoughts and actions, not only in their parenting roles, but also with colleagues at work, friends, and other family members. Parents stated experiencing a sense of development and growth, not only as a parent, but also as a person. The most significant aspects of the programme for parents that brought about these positive changes were the role of the facilitator and the cohesiveness of the group.

The psychologist appreciated the effectiveness, comprehensiveness, adaptability, quality, and flexibility of the Parent Stress Management Programme.

Confirming Data

Data gathered from participants' children with ADHD served to provide data to confirm the participants' responses to the appreciative inquiry questionnaire. This was achieved via interviews with these children on the observable behavioural changes of their parents in their interactions with them.

The children of the participants in this sample observed that their parents appeared more relaxed, approachable, and loving in their interactions with them after attending the Parent Stress Management Programme. They also stated that their parents now made them feel as part of the family by including them in decisions and activities. Generally, the children felt happier and behaved better because their parents were nicer to them.

Despite all of these positive comments, participants believed that this programme can be improved. They made several suggestions such as: separate groups for mothers and fathers, inclusion of a session with child with ADHD, funding for childcare whilst parents attend the programme, more sessions, and inclusion of the school component in the programme.

5.3 IMPLICATIONS FOR FUTURE RESEARCH

First off, the suggestion for administering the programme to a separate group for mothers and another one for fathers is worthy of discussion. While the researcher acknowledges that by including both, mothers and fathers from the same family in the group created tension and discomfort amongst other participants when the spouses disagreed and were involved in heated arguments, the reason behind including both spouses was to get a more holistic view of the interactions between parents and their children with ADHD.

Traditional family roles, in which mothers do all the nurturing and fathers withdraw into outside work activities, leave mothers overly responsible for the emotional health of all

members of the family. Many family researchers recommend sharing the role of nurturing as they have found that traditional roles contribute to dysfunction due to the alienation of the father in the emotional life of the family and the over-functioning of the mother in an impossible attempt to make everyone happy. By including both spouses, it was a step towards sharing parenting responsibilities and it also served to illustrate how differently mothers and fathers reacted to and dealt with the stress around parenting their ADHD children.

The suggestion of including the child with ADHD in at least one session is also an important point, however, the focus of this programme was not on changing actual child behaviours, therefore the children were not included in any session, the focus was on changing parents' perceptions, thoughts and behaviours. Most of the research studies to date have focused on the child with ADHD with very few studies only recently beginning to realise the impact of having an ADHD child on parents' psychological and emotional well being. Considering this study was framed by a family systems theory, all members of the family should have been included in the intervention. By including all family members, the researcher would have gained a more holistic view of parental stress in families with ADHD children. Both these suggestions are valid and are important points to consider for future implementations of the programme.

Considering the field of education in South Africa is moving towards the inclusion of learners with special needs into mainstream, more in-service training programmes accessing information about the management of learners diagnosed with ADHD should

be provided to mainstream educators. Including the school component in the programme would definitely have addressed parents' concerns regarding their child and interactions with the school personnel. As some parents have stated that their child's school is a major source of stress for them. By school personnel understanding ADHD and the impact it has on the child and his or her family, teachers can become more sensitive and empathic in their interactions with these families. As has already been stated by participants in this study that their children's teachers did not appear to have much experience in working with learners who had ADHD, it seems reasonable to recommend that more training on ADHD occur in teacher training programmes.

5.4 LIMITATIONS

One of the possible limitations of this study is that the researcher and the participants shared the same cultural context, therefore the results may not be applicable to persons from a different culture. Little is known about ADHD on the African continent because of the lack of resources, problems in access and communication and political strife. The recognition of culture and ethnicity are extremely important in the development of ADHD, as culture shapes the environment in which behaviour is defined as inappropriate (Madu, 2003).

A further limitation is the fact that only three participants were male while 5 were females. This questions whether the primary care-taking role belonged to mothers, possibly contributing to their greater distress. This also questions the motivation of the

participating fathers in attending this programme and it points to the suggestion that these fathers attended the programme in order to support their partners and not because they were seeking help in managing their parenting stress.

Some participants already received professional help from a psychologist while other participants had not, therefore, this could affect the findings of this study as all participants did not start off at the same level.

As a group programme, session content was neither individualized nor intensive. With the exception of the parenting skills session, the children's challenging behaviours were not targeted directly. The programme did not specifically target family and marital functioning. It was hoped that the group format would increase participants' social support networks. While participants were supportive in session, a more direct approach to increasing social support appears necessary, if this is to generalize to their everyday lives.

No objective measure of parent functioning was included in this study. Given the significant improvements in parenting style, together with the reported links between parenting stress, parenting practices, and the parent-child relationship, future studies should include objective measures of parent-child interaction quality and parenting style. Although the parent responses indicate that the programme was successful in achieving its goals, these results are appropriate for a single moment in time, immediately following the completion of the programme. To assess whether significant treatment effects were

mainstreamed, six and 12 month follow-up data need to be collected and analysed from the participants in this programme.

5.5 CONCLUSION

Despite these limitations, the results of the study suggest that the Parent stress Management Programme for Parents with ADHD children is effective. The negative effects of elevated parenting stress on the parent-child relationship and parenting practices argues for the inclusion of such programmes in the comprehensive management of ADHD. Treatment for ADHD should focus on enhancing parents' coping resources as well as directly targeting the child's symptoms and associated difficulties. Reducing parent distress may also help increase the effectiveness of other treatment components, including parent management training (Webster-Stratton, 1990).

The current study is the first to target the parenting stress of parents of children with ADHD so directly (Treacy et al., 2005). In doing so it makes two important contributions to the field. First, it draws attention to the needs of parents of children with ADHD. While widely acknowledged, the difficulties of parents of children with ADHD are seldom the focus of intervention. Secondly, the programme components, while not unique, together offer an innovative and promising approach to the comprehensive management of ADHD.

REFERENCES

Abidin, R. (1990). Introduction to special issue: The stresses of parenting. *Journal of Clinical Child Psychology*, 19: 298-301.

Abidin, R.R. (1992). The determinants of parenting behaviour. *Journal of Clinical Child Psychology*, 21: 407-412.

Abidin, R.R. (1995). *Parenting Stress Index-Third edition: Professional edition*. Odessa, FL: Psychological Assessment Resources.

Alexander-Roberts, C. (1995). *ADHD and teens: A parent's guide to making it through the tough years*. Dallas: Taylor.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders: DSM-IV* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders*. (4th ed. Text Revision). Washington DC: APA.

Anastopoulos, A.D., Guevremont, D.C., Shelton, T.L., & DuPaul, G.J. (1992). Parenting stress among families with attention deficit hyperactivity disorder. *Journal of Abnormal Child Psychology*, 20, 503-520.

Anastopoulos, A.D., Shelton, T.L., DuPaul, G.J., & Guevremont, D.C. (1993). Parent training for attention deficit hyperactivity disorder: Its impact on parent functioning. *Journal of Abnormal Child Psychology*, 21, 581-596.

Anderson, C.A., Hinshaw, S.P., & Simmel, C. (1994). Mother-child interactions in ADHD and comparison boys: Relationships with overt and covert externalising behaviour. *Journal of Abnormal Child Psychology*, 22: 247-265.

Auerswald, E.H. (1985). Thinking about in the Family Therapy. *Family Process*, 24 (2), 1-12.

Baddeley, A. (1972). Selective attention and performance in dangerous environments. *British Journal of Psychology*, 63: 537-546.

Baker, D.B. (1994). Parenting stress and ADHD: A comparison of mothers and fathers. *Journal of Emotional and Behavioural Disorders*, 2: 46-50.

Barker, C., Pistrang, N., & Elliot, R. (2002). *Research Methods in Clinical Psychology* (2nd Ed.). West Sussex: John Wiley & Sons, Ltd.

Barkley, R.A. (1981). Hyperactivity. In E.J. Mash and L.G. Terdal (Eds.), *Behavioural assessment of childhood disorders*. New York: Guilford.

Barkley, R.A. (1985). The social interactions of hyperactive children: Developmental changes, drug effects, and situational variation. In R. McMahon & R. Peters (Eds.), Childhood disorders: *Behavioral-developmental approaches* (pp. 218-243). New York: Brunner/Mazel.

Barkley, R.A (1989). Hyperactive girls and boys: Stimulant drug effects on mother-child interactions. *Journal of Child Psychology and Psychiatry*, 30: 379-390.

Barkley R.A. (1990). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (2nd ed.). New York: The Guilford Press.

Barkley R.A. (1997b). *ADHD and the nature of self-control.* New York: Guilford Press.

Barkley, R.A. (1998). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (2nd ed.). New York: The Guilford Press.

Barkley, R.A., Anastopoulos, A.D.,Guevremont, D.G., & Fletcher, K.F. (1992). Adolescents with attention deficit hyperactivity disorder: Mother-adolescent interactions, family beliefs and conflicts, and maternal psychopathology. *Journal of Abnormal Child Psychology*, 20: 263-288.

Barkley, R.A., Fischer, M. Edelbrock, C.S., & Smallish, L. (1990). The adolescent outcome of hyperactive children diagnosed by research criteria: I. An 8-year prospective follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29: 546-557.

Barkley, R.A., Fischer, M., Edelbrock, C.S., & Smallish, l. (1991). The adolescent outcome of hyperactive children diagnosed by research criteria: III. Mother-child interactions, family conflicts, and maternal psychopathology. *Journal of Child Psychology and Psychiatry*, 32: 233-256.

Barkley, R.A., Guevremont, D.C., Anastopoulos, A.D., & Fletcher, K.E. (1992). A comparison of three family therapy programs for treating family conflicts in adolescents with attention deficit hyperactivity disorder. *Journal of Consulting and Clinical Psychology*, 60, 450-462.

Barkley, R.A., Karlsson, J., & Pollard, S. (1985). Effects of age on the mother-child interactions of hyperactive children. *Journal of Abnormal Child Psychology*, 13: 631-638.

Barlow, D.H. & Durand, V.M. (1999). *Abnormal Psychology* (2nd ed.). USA: Brooks/Cole Publishing Company.

Beck, A.T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Beck, A. T., Rush, J., Shaw, B., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Becvar, D.S. & Becvar, R.J. (1996). *Family Therapy: A Systemic Integration.* Boston: Allyn and Bacon.

Befera, M. & Barkley, R.A. (1984). Hyperactive and normal girls and boys: mother-child interactions, parent psychiatric status, and child psychopathology. *Journal of Child Psychology and Psychiatry*, 26: 439-452.

Bell, R.Q. (1968). "A reinterpretation of the direction of effects in studies of socialization." *Psychological Review* 75: 81-95.

Bellarosa, C., & Chen, P. Y. (1997). The effectiveness and practicality of occupational stress management interventions: A survey of subject matter expert opinions. *Journal Occupational Health Psychology*, 2(3), 247-262.

Belsky, J. (1984). "The determinants of parenting: A process model." *Child Development*, 55: 83-96.

Biederman J., Newcorn J., & Sprich S. (1991). Comorbidity of Attention Deficit Hyperactivity Disorder with Conduct, Depressive, Anxiety, and other disorders. *American Journal of Psychiatry*, 148(5), 564-577.

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Biederman, J., Faraone, S.V., & Lapey, K. (1992). Comorbidity of diagnosis in attention deficit hyperactivity disorder. In G. Weiss (Ed.), *Child and adolescent psychiatric clinics of North America: Attention-deficit hyperactivity disorder* (pp. 335-360). Philadelphia: Saunders.

Biederman, J., Milberger, S., Faraone, S.V., Kiely, K., Guite, J., & Mick, E. (1995). Family-environment risk factors for attention-deficit/hyperactivity disorder. *Archives of General Psychiatry*, 52: 464-470.

Bos C.S. & Vaughn S. (1998). *Strategies for teaching students with learning and behavior problems.* Needham Heights, MA: Allyn and Bacon.

Boyce, G.C., Behl, D., Mortensen, L., & Akers, J. (1991). Child characteristics, family demographics and family processes: their effects on the stress experienced by families of children with disabilities. *Counseling Psychology Quarterly*, 4, 273-288.

Brammer, L.M. & Macdonald, G. (1996), (6th Edition). *The Helping Relationship – Process and skills.* Massachusetts A. Simon & Schuster Company.

Braswell, L., August, G.J., Bloomquist, M.L., Realmuto, G.M., Skare, S.S., & Crosby, R.D. (1997). School-based secondary prevention for children with disruptive behavior: Initial outcomes. *Journal of Abnormal Child Psychology*, 25: 197-208.

Breakwell, G.M., Hammond, S., & Fife-Schaw, C. (1998). *Research Methods in Psychology.* London: SAGE Publications Ltd.

Breen, M.J. & Barkley, R.A. (1988). Child psychopathology and parenting stress in girls and boys having Attention Deficit disorder with Hyperactivity. *Journal of Paediatric Psychology,* 13: 265-280.

Breggin, P.R. & Breggin, G.R. (1995). The hazards of treating "Attention-Deficit/Hyperactivity Children" with Methylphenidate (Ritalin). *The Journal of College Student Psychotherapy,* 10 (2) 55-72.

Bronfenbrenner, U. (1979). *The ecology of human development: experiments by nature and design.* Cambridge, Mass.: Harvard University Press.

Brown, J.D. & McGill, K.L. (1989). The cost of good fortune: When positive life events produce negative health consequences. *Journal of Personality and Social Psychology,* 57: 1103-1110.

Bryman, A. (1988). *Quantity and quality in social research.* London: Unwin Hyman.

Burns, D. (1980). *Feeling good: The new mood therapy.* New York: Avon.

Caldwell, B.M. & Bradley, R.H. (1984). *Home observation for measurement of the environment.* Little Rock, Ark.: University of Arkansas.

Cameron, S.J. & Orr, R.R. (1989). Stress in families of school-aged children with delayed mental development. *Canadian Journal of Rehabilitation, 2,* 137-144.

Canaff, A.L., (2004). Recognising job burnout. In *The Counselling Corner* by the American Counselling Association.

Cantwell, D.P. (1996). Attention deficit disorder: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry,* 35: 978-987.

Chronis, A.M., Pelham, W.E., Roberts J.E., Gamble, S.A., Gnagy, E., & Burrows-Maclean, L. (1999, November). *Two approaches to managing stress in parents of children with ADHD.* Poster session presented at the annual meeting of the Association for Advancement of Behavior Therapy, Toronto.

Cooperrider, D. L. (1996). *Appreciative inquiry: A constructive approach to organization development and change.* Cleveland, OH: Weatherhead School of Management.

Copeland E.D., & Love N.L. (1995). *Attention, please: ADHD/ADD.* Plantation, FL: Specialty Press.

Corey, G. & Corey, M.S. (1977). *Groups: Process and Practice.* Monterey, California: Books/Cole.

Crnic, K. & Acevedo, M. (1995). Everyday stresses and parenting. In Bornstein, M.H., (ed.) *Handbook of Parenting,* 4: 277-298.

Croog, S.H. (1970). The Family as a source of stress. In Sol Levine and Norman A. Scotch (Eds.), *Social stress* (pp. 19-53). Aldine Publishing Company.

Cunningham, C.E., & Barkley, R.A. (1979). The interactions of normal and hyperactive children with their mothers in free play and structured tasks. *Child Development,* 50: 217-224.

Cunningham, C.E., Bennes, B.B., & Siegel, L.S. (1988). Family functioning, time allocation, and parental depression in the families of normal and ADHD children. *Journal of Clinical Child Psychology,* 17: 169-177.

Danforth, J.S., Barkley, R.A., & Strokes, T.F/ (1991). Observations of parent-child interactions with hyperactive children: Research and clinical implications. *Clinical Psychology Review,* 11: 703-727.

Denzin, N.K. (1978). *The Research Act.* New York: McGraw-Hill.

Dohrenwend, B.S. (1973). Life events as stressors: A methodological inquiry. *Journal of Health and Social Behavior,* pp. 167-175.

Duboust, S. & Knight, P. (1995). *Group Activities for Personal Development.* United Kingdom: Winslow Press Limited.

Dulcan, M., Dunne, J., Ayres, W., Arnold, V., Benson, S., & Bernet, W. (1997). Practice parameters for the assessment and treatment of children, adolescents, and adults with attention deficit/hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry,* 36: 85S-121S.

Dunn, M. (1997). ADHD: The Parent's Challenge. *Pine Rest Mental Health.*

DuPaul G.J., & Stoner G. (1994). *AD/HD in the schools: Assessment and intervention strategies.* New York: Guilford Press.

Ellis, A. (1962). *Reason and emotion in psychotherapy.* New York: Lyle Stuart.

Essau, C.A. & Petermann, F. (1997). *Developmental Psychopathology.* Germany: Hardwood Academic Publishers.

Eyberg, S.M., Boggs, S.R., & Rodriguez, C.M. (1992). Relationships between maternal parenting stress and child disruptive behavior. *Child and Family Behavior Therapy,* 14, 1-9.

Fergusson, D.M., Lynskey, M.T., & Horwood, L.J. (1997). Attention difficulties in middle childhood and psychosocial outcomes in young adulthood. *Journal of Child Psychology and Psychiatry,* 38: 633-644.

Fischer, M. (1990). Parenting stress and the child with attention deficit hyperactivity disorder. *Journal of Clinical Child Psychology,* 19, 337-346.

Forehand, R., & McMohan, R., (1981). *The noncompliant child.* New York: Guilford.

Forman, S. (1990). Rational-emotive therapy: Contributions to teacher stress management. *School Psychology Review,* 19(3), 315-321.

Fredrick B.P., & Olmi D.J., (1994). Children with Attention Deficit/Hyperactivity Disorder: A review of the literature on social skills deficits. *Psychology in the Schools,* 31: 288-296.

Frey, R.J. (2003). Stress health article. In *Gale Encyclopaedia of Mental Disorders.* Detroit: The

    Gale Group Inc.

Geertz, C. (1973). *The interpretation of cultures.* New York: Basic Books.

Gergen, K.J. (1971). *The concept of self.* New York: Holt, Rinehart and Winston.

Giedd, J.N., Castellanos, F.X., Casey, B.J., Kozuch, P., King, A.C., Hambuger, S.D., &

    Rapoport, J.L. (1994). Quantitative morphology of the corpus callosum in attention

    deficit hyperactivity disorder. *American Journal of Psychiatry,* 151: 665-669.

Gilberg, C., Melander, H., von Knorring, A.L., Janols, L., Thernlund, G., Hagglof, B., Eidevall-

    Wallin, L., Gustafson, P., & Kopp, S. (1997). Long-term stimulant treatment of children

    with attention-deficit hyperactivity disorder symptoms: A randomized, double-blind,

    placebo-controlled trail. *Archives of General Psychiatry,* 54: 857-864.

Glass, D., Snyder, M.J, & Hollis, J. (1974). Time urgency and the Type A coronary prone

    behavior pattern. *Journal of Applied Social Psychology,* 4: 125-140.

Goldfried, M.R. (1977). The use of relaxation and cognitive relabeling as coping skills. In R.B.

    Stuart (Ed.), *Behavioural self-management: Strategies and outcomes.* New York:

    Brunner/Mazel.

Goldstein S., & Goldstein M. (1990). *Managing attention disorders in children.* New York: Wiley.

Gomez, R., & Sanson, A.V. (1994). Mother-child interactions and non-compliance in hyperactive boys with and without conduct problems. *Journal of Child Psychology and Psychiatry,* 35: 477-490.

Grant, I., Sweetwood, H.L., Yager, J., & Gerst, M.S. (1981). *Archives of General Psychiatry,* 38: 335-339.

Gross, E. (1970). Work, organization and stress. In Levine Sol & N.A. Scotch (Eds.), *Social stress* (pp. 54-110). Chicago: Aldine Publishing Company.

Guba, E.G. (1978). *Toward a methodology of naturalistic inquiry in educational evaluation (CSE Monograph Series in Evaluation No. 8).* Los Angeles: Centre for the study of Evaluation.

Haley, J. (1976). *Problem solving therapy.* San Francisco: Jossey-Bass.

Harrison, C. & Sofrofoff, K. (2002). ADHD and parent psychological distress: Role of demographics, child-behavioural characteristics, and parental cognitions. *Journal of the American Academy of child and Adolescent Psychiatry,* 41: 703-711.

Hechtman, L. (Ed.) (1996). *Do they grow out of it? Long-term outcomes of childhood disorders.* Washington, DC: American Psychiatric Press.

Henker, B. & Whalen, C.K. (1989). Hyperactivity and attention deficits. *American Psychologist*, 44: 216-223.

Herrerias, C.T., Perrin, J.M., & Stein, M.T. (2001). The child with ADHD: Using the AAP Clinical Practice Guideline. *American Academy of Family Physicians.*

Higgins, E.T. (1989). Self-discrepancy theory: What patterns of self-beliefs cause people to suffer? *Advances in Experimental Social Psychology*, 22: 93-136.

Hinshaw, S.P. (1992). Externalizing behavior problems and academic underachievement in childhood and adolescence: Causal relationships and underlying mechanisms. *Psychological Bulletin*, 111: 127-155.

Holmes, T., & Rahe, R. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research,* 11: 213-218.

Holmes, T.H., & Masuda, M. (1974). Life change and illness susceptibility. In B. S. Dohrenwend & B. P. Dohrenwend (Eds.), *Stressful life events* (pp. 45-71). New York: Wiley.

House, J.S. & Harkins, E.B. (1976). Why and when is status inconsistency stressful? *American Journal of Sociology*, 81: 395-412.

Jensen, P.S., Hinshaw, S.P., Swanson, J.M., Greenhill, L.L., Conners, C.K., Arnold, L.E., Abikoff, H.B., Elliot, G., Hectman, L., Hoza, B., March, J.S., Newcorn, J.H., Severe, J.B., Vitiello, B., Wells, K., & Wigal, T. (2001). Findings from the NIMH Multimodal Treatment Study of ADHD (MTA): Implications and applications for primary care providers. *Journal of Development and Behavioral Pediatrics.* 22: 60-73.

Johnston, C. (1996). Parent characteristics and parent-child interactions in families of nonproblem children and ADHD children with higher and lower levels of oppositional-defiant disorder. *Journal of Abnormal Child Psychology,* 24: 85-104.

Johnston, C. & Leung, D.W. (2001). Effects of medication, behavioural, and combined treatment on parents' and children's attributions for the behaviour of children with attention-deficit hyperactivity disorder. *Journal of Consulting and Clinical Psychology,* 69: 67-76.

Johnston, C., & Mash, E.J. (2001). Families of children with attention deficit/hyperactivity disorder: Review and recommendations for future research. *Clinical Child and Family Psychology Review,* 4, 183-206.

Kanel, K. (2003). *A Guide to Crisis Intervention* (2nd ed.). USA: Brooks/Cole.

Kaplan, H.B. (1983). *Psychosocial Stress: Trends in Theory and Research.* New York: Academic Press Inc.

Kaplan, H.B. (editor) (1996). *Psychosocial stress: Perspectives on structure, Theory, Life Course, And Methods.* California: Academic Press, Inc.

Kaplan, B., Crawford, S., Fisher, G., & Dewey, D. (1998). Family dysfunction is more strongly associated with ADHD than with general school problems. *Journal of Attention Disorders,* 2 (4), 209-216.

Kazdin, A.E. & Whitley, M.K. (2003). Treatment of parental stress to enhance therapeutic change among children referred for aggressive and antisocial behaviour. *Journal of Consulting and Clinical Psychology.* 71 (3): 504-515.

Keeney, B.P. (1979). Ecosystemic Epistemology: An Alternative Paradigm for Diagnosis. *Family Process,* 18 (2), 117-129.

Kendall, J. (1998). Outlasting disruption: The process of re-investment in families with ADHD children. *Qualitative Health Research,* 8 (6), 839-857.

Klein, R.G. & Mannuzza, S. (1991). Long-term outcome of hyperactive children: A review. *Journal of the American Academy of Child and Adolescent Psychiatry,* 30: 383-387.

Kreppner, K. & Lerner, R.M. (Eds.), (1989). *Family systems and life-span development.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Lahey, B.B., Piacentini, J.C., McBurnett, K., Stone, P., Hartdagen, S., & Hynd, G. (1988). Psychopathology in the parents of children with conduct disorder and hyperactivity. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27: 163-170.

Latson, S.R. (1995). Preventing Parent Burn Out: Model for Teaching Effective Coping Strategies to Parents of Children with Learning Disabilities. *Learning Disabilities Association of America Newsbrief.*

Lazarus, R.S. (1966). *Psychological stress and the coping process.* New York: McGraw-Hill.

Lazarus, R.S. (1981). The stress and coping paradigm in C. Eisdorfer and D. Cohen (eds.), *Models for Clinical Psychopathology.* New York: Spectrum.

Lehrer, P.M. & Woolfolk, R.L. (Eds.), (1993). *Principles and Practice of Stress Management* (2nd ed.). New York: The Guilford Press.

Lensch, C.R. (2000). *Making Sense of Attention Deficit/Hyperactivity Disorder.* Westport, CT: Bergin & Garvey.

Lenski, G.E. (1954). Status crystallization: A non-vertical dimension of social status. *American Sociological Review,* 19: 405-413.

Lewinsohn, P. M. (1974). A behavioral approach to depression. In R. J. Friedman & M. M. Katz (Eds.). *The psychology of depression: Contemporary theory and research* (pp. 157-178). New York: John Wiley & Sons.

Locke, H.J., & Wallace, K.M. (1959). Short marital adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living,* 21: 251-255.

Lomofsky, L., Roberts, R. & Mvambi, N. (1999). The inclusive classroom. In Engelbrecht, P., Green, L., Naicker, S. & Engelbrecht, L. (Eds). *Inclusive education in action in South Africa.* Pretoria: J.L. van Schaik Publishers.

Madu, N.S. (2003). *Contributions to Psychotherapy in Africa.* Polokwane (Pietersburg): UNIN Press.

Mako, K. (2002). *The prevalence of attention deficit/ hyperactivity disorder (ADHD) among clinically referred and community based children:* A comparative study. Unpublished Masters' Dissertation, University of the North, South Africa.

Mandler, G. (1982). Stress and thought processes. In Leo Goldberg & S. Breznitz (Eds.), *Handbook of stress: Theoretical and clinical aspects,* (pp. 88-104). New York: The Free Press.

Markus, H. (1977). Self-schemata and processing of information about the self. *Journal of Personality and Social Psychology,* 35: 63-78.

Markus, H., & Nurius, P. (1986). Possible selves: The interface between motivation and the self-concept. In K. Yardley & T. Honess (Eds.), *Self and identity: Psychosocial perspectives.* New York: Wiley.

Mash, E.J. & Johnston, C. (1982). A comparison of motherhood interactions of younger and older hyperactive and normal children. *Child Development,* 53: 1371-1381.

Mash, E.J. & Johnston, C. (1983). Sibling interactions of hyperactive and normal children and their relationship to reports of maternal stress and self-esteem. *Journal of Clinical Child Psychology,* 12: 91-99.

Mash, E.J., & Johnston, C. (1983). Parental perceptions of child behaviour problems, parenting self-esteem, and mothers' reported stress in younger and older hyperactive and normal children. *Journal of Consulting and Clinical Psychology,* 51, 86-99.

Mash, E.J., & Johnston, C. (1990). Determinants of parenting stress, illustrations from families of hyperactive children and families of physically abused children. *Journal of Clinical Child Psychology*, 19: 313-328.

Mattesich, P. & Hill, R. (1987). "Life cycle and family development." In: M.B. Sussman & S.K. Steinmetz (eds.). *Handbook of Marriage and the Family*. New York: Plenum Press, pp. 437-470.

Meichenbaum, D.H. (1977). *Cognitive Behaviour Modification: An integrative approach*. New York: Plenum Press.

Mehl-Madrona, L. (2003). *Attention-Deficit/Hyperactivity Disorder (ADHD)*. Available online at: http://www.healing-arts.org . Retrieved: December 2006.

Meyer, A. (1998). Attention deficit/hyperactivity disorder among North Sotho speaking primary school children in South Africa: Prevalence and sex ratios. *Journal of Psychology in Africa*, 8: 186-195.

Meyer, A., Eilersten, D.E., Sundet, J.M., Tshifularo, J.G., & Sagvolden, T. (2002). Screening of South African primary school children shows cross-cultural similarities in ADHD symptoms. *South African Journal of Psychology*.

Miller, G. (1998). Mums of special needs children. Available online at: http://www.womanlinks.com . Retrieved: December 2006.

Minuchin, S. (1974). *Families and Family Therapy*. Cambridge, MA: Harvard University Press.

Mirowsky, J., & Ross, C.E. (1989). *Social Causes of Psychological Distress*. New York: Adline.

Murphy, K., & Barkley, R.A. (1996). Attention deficit hyperactivity disorder in adults. *Comprehensive Psychiatry*, 37: 393-401.

Neylan, T.C. (1998). Hans Selye and the field of stress research. *Neuropsychiatry Classics*, 10 (2), 230-231.

Osborne, J.W. (1994). Some similarities and differences among phenomenological and other methods of psychological qualitative research. *Canadian Psychology*, 35 (2), 167-189.

Palazzoli, S., Boscolo, L., Cecchin, G., & Prata, G. (1980). Hypothesising, Circularity, Neutrality: Three Guidelines for the Conductor of the Session. *Family Process*, 19 (1), 3-12.

Patterson, G.R., Dishion, T., & Reid, J. (1992). *Antisocial Boys*. Eugene, OR: Castalia.

Patton, M.Q. (1987*). How to Use Qualitative methods in Evaluation.* Newbury Park, California: SAGE Publications, Inc.

Patton, M.Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Newbury Park, CA: Sage Publications, Inc.

Pearlin, L.I. (1975a). "Sex roles and depression." Pp. 191-207 in Nancy Datan and Leon H. Ginsberg (eds.), *Life-Span Developmental Psychology: Normative Life Crises.* New York: Academic Press.

Pearlin, L.I. (1980a). "The life cycle and life strains." Pp. 349-360 in Hubert M. Blalock, Jr. (ed.), *Sociological Theory and Research.* New York: The Free Press.

Pearlin, L.I. (1980b). "Life strains and psychological distress among adults." Pp. 174-192 in Neil J. Smelser and Erik H. Erikson (eds.), *Themes of Work and Love in Adulthood.* Cambridge: Harvard University Press.

Pearlin, L.I., Lieberman, E.G., Menaghan, E.G., & Mullan, J.T. (1981). The stress process. *Journal of Health and Social Behaviour,* 22: 337-356.

Pearlin, L.I., & McCall, M.E. (1990). Occupational stress and marital support: A description of microprocesses. In J. Eckenrode & S. Gore (Eds.), *Stress Between Work and Family* (pp. 39-60). New York: Plenum Press.

Pelham, W.E., Carlson, C., Sams, S.E., Vallano, G., Dixon, M.J., & Hoza, B. (1993). Separate and combined effects of methyl-phenidate and behaviour modification on boys with attention deficit-hyperactivity disorder in the classroom. *Journal of Consulting and Clinical Psychology*, 61: 506-515.

Pelham, W.E. and Lang, A.R. (1999). Can your children drive you to drink? *Alcohol Research & Health*. Vol. 23, (4).

Pelham, W. and Bender, M.E. (1982). Peer relationships in hyperactive children: Description and Treatment. In K.D. Gadow and I. Bialer (Eds), *Advances in Learning and Behavioural Disabilities*. Greenwich: CT: JAI.

Pelham, W.E., & Milich, R. (1984). Peer relationships in children with hyperactivity/attention deficit disorder. *Journal of Learning Disabilities,* 17:560-567.

Pentecost, D. (2000). *Parenting the ADD Child: Can't Do? Won't Do?* London: Jessica Kingsley Publishers.

Pfiffner, L.J. & Barkley, R.A. (1990). Educational placement and classroom management. In R.A. Barkley (ed.), *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment,* (pp.498-539). New York: Guilford Press.

Pisterman, S., Mcgrath, P., Firestone, P., Goodman, J., Webster, I., Mallory, R., & Goffin, B. (1992). The effects of parent training on parenting stress and sense of competence. *Canadian Journal of Behavioural Science,* 24, 41-58.

Pitzer, R. (1998). Coping With Parental Stress. Available online at: http://www.extension.umn.edu. Retrieved: December 2006.

Podolski, C-L. & Nigg, J.T. (2001). Parent stress and coping in relation to child ADHD severity and associated child disruptive behavior problems. *Journal of Clinical Child Psychology,* 30: 503-513.

Point, V. (2003). What causes ADHD? Available online at: http://www.mentalhealthmatters.com. Retrieved: January 2007.

Rabiner, D. (2002). Stress and coping in parents of children with ADHD. *Attention Research Update.* Available online at: http://www.helpforadd.com .Retrieved: January 2007.

Relvas, A.P. (1997). Family Therapy: Foundations and Techniques. *Psychotherapy: New Perspectives on Theory, Practice, and Research.* Edited by Hawkins, P.J. and Nestoros, J.N. Athens: Ellinika Grammata Publ.

Reuben, H. (1949). *Families under Stress.* Westport, Conn.: Greenwood Press.

Robson, C. (1993). *Real world research: A resource for social scientists and practitioner –researchers.* Oxford: Blackwell.

Rodgers, A.Y. (1998). Multiple sources of stress and parenting behavior. *Children and Youth Services Review*, 20: 525-546.

Ross, D.M. & Ross, S.A. (1982). *Hyperactivity: Current Issues, Research, and Theory* (2nd ed.). New York: John Wiley & Sons, Inc.

Rossi, P.H., Freeman, H.E., & Lipsey, M.W. (1999). *Evaluation: A systemic approach.* (6th ed.). Thousand Oaks, C.A.: Sage

Santrock, J.W. (2002). *Life-span development.* New York: Mcgraw-Hill Companies.

Schneewind, K.A., (1989). "Contextual Approaches to Family Systems Research: The Marco-Micro Puzzle." In: K. Kreppner and R.M. Lerner, (Eds.). *Family Systems and Lifespan Development.* Hillsdale, NJ: Lawrence Erlbaum Associates, pp. 197-221.

Scriveri, M. (1972). The methodology of evaluation. In C.H. Weiss (ed.), *Evaluation action programs.* Boston, MA: Allyn & Bacon.

Sdorow, L.M. (1993). *Psychology.* Dubuque: Brown and Benchmark.

Selye, H. (1976). *The stress of life* (Revised edition). New York: McGraw Hill Book Company, Inc.

Shadish, W.R., Cook, T.D., & Leviton, L.C. (1991). *Foundations of program evaluation: Theories of practice.* Newbury Park: Sage.

Shantall, H.M. (1996). *A Heuristic Study of the meaning of Suffering among Holocaust Survivors.* Unpublished doctoral thesis, University of South Africa.

Shapiro, D.H. (1992). Clinical applications of a control model of psychological health: Two case studies of stress-related disorders. *Psychotherapy Patient,* 7: 169-198.

Shelton, K. (1998). A Typology of Management Styles in Families with Children with ADHD. *Journal of Family Nursing.* 9 (2), 257-280.

Shlenker, B.R. (1987). Threats to identity: Self-identification and social stress. In C. Snyder & C. Ford (Eds.), *Coping with negative life events: Clinical and social psychological perspectives* (pp. 273-321). New York: Plenum Press.

Siegert, R.J., Patten, M.D., & Walkey, F.H. (1987). Development of a Brief Social Support Questionnaire. *New Zealand Journal of Psychology,* 16: 79-83.

Sigel, I.E., McGillicuddy – Delisi, A.V., & Goodnow, J.J. (Eds.), (1992). *Parental Belief Systems: The psychological consequences for children.* New Jersey: Lawrence Erlbaum Associates, Inc.

Sigelman, C.K. Rider, E.A. (2003). *Life-span human development.* Belmont, CA: Wadsworth.

Silburn, S.R., Zubrick, S.R., Garton, A., Gurrin, L., Burton, P., Dalby, R., Carlton, J., Shepherd, C., & Lawrence, D. (1996). *Western Australian Child Health Survey: Family and Community Health.* Perth, Western Australia: Australian Bureau of Statistics and the TVW Telethon Institute for Child Health Research.

Silver, L. (1999). *Dr. Larry Silver's Advice to Parents on ADHD.* United States: Times Books.

Stein, M.R., Vidich, Arthur J., & White, D.M. (1960). *Identity and anxiety: Survival of the person in mass society.* Glencoe, IL: The Free Press.

Stiles, W.B. (1993). Quality control in qualitative research. *Clinical Psychology Review,* 13 (6), 593-618.

Stotland, E. & Pendleton, M. (1989). Workload, stress, and strain among police officers. *Behavioural Medicine,* 15: 5-17.

Strauss, A.A. & Lehtinen, L.E. (1947). *Psychopathology and education of the brain-injured child.* New York: Grune & Stratton.

Stryker, S., & Macke, A. (1978). Status inconsistency and role conflict. *Annual Review of Sociology,* 4: 57-90.

Swann, W.B.J. (1987). Identity negotiation: Where two roads meet. *Journal of Personality and Social Psychology,* 53: 1038-1051.

Swensen, A.R., Birnbaum, H.G., Secnik, K., Marynchenko, M., Greenberg, P., & Claxton, A. (2003). ADHD: Increased costs for parents and their families. *American Academy of Child and Adolescent Psychiatry.* 42 (12): 1415-1423.

Szatmari, P., Offord, D.R., & Boyle, M.H. (1989). Ontario child health study: prevalence of attention deficit disorder with hyperactivity. *Journal of Child Psychology and Psychiatry,* 30: 219-230.

Tallmadge, J. & Barkley, R.A. (1983). The interaction of hyperactive and normal boys with their mothers and fathers. *Journal of Abnormal Child Psychology,* 11: 565-579.

Taylor, E., Sandberg, S., Thorley, G., & Giles, S. (1991). *The epidemiology of childhood hyperactivity.* London: Oxford University Press.

Thoits, P.A. (1983). Dimensions of life events that influence psychological distress: An evaluation and synthesis of the literature. In H.B. Kaplan (Ed.), *Psychosocial stress: Trends in theory and research* (pp. 157-191). New York: Academic Press.

Treacy, L., Tripp, G., & Baird, A. (2005). Parent Stress Management Training for Attention-Deficit/Hyperactivity Disorder. *Behaviour Therapy*, 36: 223-233.

Watkins, J. M., & Mohr, B. J. (2001). *Appreciative Inquiry: Change at the Speed of Imagination.* San Francisco: Wiley.

Webster-Stratton, C. (1990). Stress: A potential disrupter of parent perceptions and family interactions. *Journal of Clinical Child Psychology*, 19: 302-312.

Webster-Stratton, C., & Spitzer, A. (1996). Parenting a young child with conduct problems. In T.H. Ollendick & R.J. Prinz (Eds.), *Advances in clinical child psychology* (Vol. 18, pp. 1-62). New York: Plenum.

Webster-Stratton, C. (1997). From parent training to community building. *Families in Society*, 78 (2), 156-171.

Weinberg, H.A. (1999). Parent training for attention deficit hyperactivity disorder: Parental and child outcome. *Journal of Clinical Psychology*, 55, 907-913.

Wells, K.C., Epstein, J.N., Hinshaw, S.P., Conners, C.K., Klaric, J., Abikoff, H.B., Abramowitz, A., Arnold, L.E., Elliott, G., Greenhill, L.L., Hechtman, L., Hoza, B., Jensen, P.S., March, J., Pelham Jr., W., Pfiffner, L., Severe, J., Swanson, J., Vitiello, B., & Wigal, T. (2000). Parenting and family stress treatment outcomes in attention deficit hyperactivity disorder (ADHD): An empirical analysis of the MTA study. *Journal of Abnormal Child Psychology*, 28, 543-553.

Wender, P.H. (2000). *Attention-Deficit Hyperactivity Disorder in Children and Adults.* Oxford: Oxford University Press.

Whitney, D. (1998). Let's change the subject and change our organization: An Appreciative Inquiry approach to organization change. *Career Development International*, 3(7), 314-319.

Winter, G. (2000). A comparative discussion of the notion of 'validity' in qualitative and quantitative research. *The Qualitative Report* 4 (3). Available online at: http://www.nova.edu/sss/QR4-3/winter.html. Retrieved: January 2007.

Young, M. (1988). Understanding identity disruption and intimacy: One aspect of post-traumatic stress. *Contemporary Family Therapy: An International Journal*, 10: 30-43.

Zametkin, A.J., Nordahl, T.E., Gross, M., King, A.C., Semple, W.E., Rumsey, J., Hamburger, S., & Cohen, R.M. (1990). Cerebral glucose metabolism in adults with hyperactivity of childhood onset. *New England Journal of Medicine*, 323: 1361-1366.

Zametkin, A.J., Nordahl, T.E. & Gross, M. (2000). *Causes of ADHD*. Available online at: http://www.healing-arts.org. Retrieved: January 2007.

Zentall, S.S. (1989). Attentional cuing in spelling tasks for hyperactive and comparison regular classroom children. *Journal of Special education*, 23 (1), 83-93.

Zubrick, S.R., Silburn, S.R., Garton, A., Burton, P., Dalby, R., Carlton, J., & Lawrence, D. (1995). *Western Australian Child Health Survey: Developing Health and Well-being in the Nineties*. Perth, Australia: Australian Bureau of Statistics and the Institute for Child Health Research.

APPENDIX A

ATTENTION: PARENTS

DO YOU HAVE A CHILD / CHILDREN WHO HAVE BEEN DIAGNOSED WITH ATTENTION – DEFICIT/HYPERACTIVITY DISORDER (ADHD)?

ARE YOU EXTREMELY STRESSED BY YOUR CHILD'S UNACCEPTABLE RESPONSES AND BEHAVIOURS?

IS THIS CAUSING PROBLEMS IN YOUR FAMILY LIFE?

DO YOU FEEL YOU NEED HELP / SUPPORT URGENTLY?

IF YOU ANSWERED " YES" TO ANY OF THE ABOVE AND WOULD LIKE TO PARTICIPATE IN A STRESS MANAGEMENT PROGRAMME FOR PARENTS OF CHILDREN DIAGNOSED WITH ADHD RUN BY A REGISTERED EDUCATIONAL PSYCHOLOGIST, AS PART OF HER DOCTORAL RESEARCH, THEN PLEASE CONTACT 031 – 563 0961 TO FIND OUT MORE.

APPENDIX B – WRITEN CONSENT FORM

TO PARTICIPANTS IN THIS STUDY:

I am a doctoral student at the University of Zululand. Part of the requirements for my doctorate in Community Psychology is to conduct research. The subject of my doctoral research is: **Evaluation of a stress management programme for parents of children diagnosed with Attention – Deficit / Hyperactivity Disorder (ADHD).**

The stress management programme will be run for nine weeks. You will also be required to assess the success of the programme anonymously, making recommendations for improvements after completion of the programme.

This programme was developed by a group of psychologists in New Zealand and after consulting with them, permission was granted to adapt the programme and run it here in South Africa. The aim of the programme is to teach parents to manage their stress more effectively.

Each session will take approximately two hours (2hrs), and will include a tea / coffee break. Sessions will start at 6: 30 pm. and will be run on Wednesdays at my psychology practice, Suite 2, Effingham Dental & Therapy Centre, 312 Effingham Road, Effingham Heights, Durban North. After the programme is terminated, I will require your permission to interview your child with ADHD very briefly.

My goal is to analyse the material from all the sessions conducted, to analyse all responses from the questionnaires and the interview with your children, to look for any improvement in the way you manage your stress around parenting your ADHD child and to evaluate whether this stress management programme has been successful in teaching parents to manage their stress more effectively.

Because we are a research project, from time to time, we will be asking for your consent to audio-tape group sessions. I will not use your names and all information will remain

anonymous. The tapes will be kept for the length of the study only, and once they have been checked, they will be destroyed.

You may at any time withdraw from the study. Any information used from the group sessions will only be used for research purposes.

I, _____ (NAME IN BLOCK LETTERS) have read the above, understand the nature of this research study and agree to participate under the conditions stated above.

_____   _____

Signature of participant   Date

APPENDIX C – BIOGRAPHICAL QUESTIONNAIRE
(Confidential information)

AGE   _____

GENDER   _____

MARITAL STATUS _____

 AGES OF CHILDREN   _____

                        _____

                        _____

                        _____

EMPLOYMENT STATUS _____

IS YOUR ADHD CHILD ON MEDICATION? WHAT MEDICATION?

_____

HOW MANY OF YOUR CHILDREN ARE ADHD? _____

CONTACT TELEPHONE NOS. HOME: _____

                       WORK: _____

                       CELL: _____

APPRECIATIVE INQUIRY QUESTIONNAIRE

This purpose of this study is to evaluate the programme you have just participated in, namely, the Parent Stress Management Programme for Parents of Children with ADHD. Please answer the following questions as honestly and accurately as possible on the answer sheets provided.

QUESTIONS:

1. DESCRIBE YOUR EXPERIENCE OF THE PROGRAMME.

2. WHAT DO YOU APPRECIATE ABOUT THE PROGRAMME? WHAT ARE THE STRENGTHS OF THE PROGRAMME?

3. HOW CAN THIS PROGRAMME BE IMPROVED?

INTERVIEW SCHEDULE FOR CHIILDREN

You do know that your mum and dad/ mum has been attending a parent programme for several weeks now. Have you noticed any changes in them, or the way in which they now interact or respond to you? Can you please tell me about them?

APPENDIX F

SCIENTIFIC ARTICLE

AN EVALUATION OF A PARENT STRESS MANAGEMENT INTERVENTION FOR PARENTS OF CHILDREN WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

BY Y. PRITHIVIRAJH AND PROF.S.D.EDWARDS

SUMMARY

A qualitative, phenomenological approach incorporating triangulation, process evaluative and appreciative inquiry techniques was used to evaluate parental experiences of participating in a stress management programme for parents of children with Attention Deficit Hyperactivity Disorder (ADHD). Parents experienced the program as bringing about empowerment, group cohesion, cognitive restructuring, behaviour modification, growth, development and change. Children viewed their parents as having become more relaxed, approachable, inclusive and loving. An independent psychologist evaluated the programme positively in terms of its quality, effectiveness, flexibility, adaptability and comprehensiveness. The research concludes with ways of improving the programme for future management of children with ADHD.

INTRODUCTION

The purpose of this study was to evaluate the experiences of parents' participation in a stress management programme for parents with children diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD).

"They can't sit still; they don't pay attention to the teacher; they mess around and get into trouble; they try to get others into trouble; they are rude; they get mad when they don't get their own way" (Henker & Whalen, 1989, p.216).

Children sometimes seem to have boundless energy. They run, play, talk, laugh – and squirm, shout, have temper tantrums, interrupt others when they talk or don't want to share toys. It's just part of being a kid. But for some children, these actions are a sign of a behavioural problem called ADHD.

Important indirect consequences of ADHD include effects on parent-child interactions and, more generally, the family environment. The problematic relationship between children with ADHD and their parents is best described as a "negative-reactive" response pattern. According to Johnston (1996), this pattern develops when parents of ADHD children react to their child's disruptive behaviours by displaying more commanding behaviour, more disapproval, fewer rewards for compliant behaviour, and more overall negative behaviour than parents of normal children. Kazdin and Whitley (2003) also

found that the stress of the parent influences parent disciplinary practices which directly promotes and escalates aggressive and oppositional child behaviour, that is, the stress of parents appear to increase parent irritability and attention towards deviant child behaviour.

Current research on parenting and ADHD has revealed that ADHD has important consequences to the sufferers, as well as their parents and siblings (Swensen, Birnbaum, Secnik, Marynchenko, Greenberg, & Claxton, 2003). More specifically, there has been a discovery that parents experience greater stress with children with ADHD than other parents with children without ADHD, because of the additional parenting challenges they face (Rabiner, 2002).

On reviewing the existing literature on parental stress associated with children who have been diagnosed with ADHD, only a few studies existed and all were conducted overseas. In South Africa there appeared to be a paucity of research on this topic. Also, all the research studies that have been conducted on parental stress with ADHD children were quantitatively analysed, with a clear scarcity of published literature that draws from parental experiences of parenting a child with ADHD (Anastopoulos, Shelton, DuPaul, & Guevremont, 1993; Weinberg, 1999; Wells, Epstein, Hinshaw, Conners, Klaric, Abikoff, Abramowitz, Arnold, Elliot, Greenhill, Hechtman, Hoza, Jensen, March, Pelham, Pfiffner, Severe, Swanson, Vitiello, & Wigal, 2000; Barkley, Guevremont, Anastopoulos, & Fletcher, 1992; Chronis, Pelham, Roberts, Gamble, Gnagy, & Burrows-Maclean, 1999; Treacy, Tripp, & Baird, 2005).

The purpose of the present study was to explore and understand parents' experiences of participating in the Parent Stress Management Programme for parents of children with ADHD. If the programme is effective in treating and managing parenting stress of the participants then it is hypothesized that the relationship between parent-child interactions would improve, resulting in more positive child-behaviours. This was investigated via a qualitative evaluation of the programme utilizing an appreciative inquiry methodology as well as incorporating aspects of process evaluation. Based upon these informed observations, multidimensional treatment programmes can be recommended for families with children with ADHD.

CONCEPTS USED IN THIS STUDY

Attention-Deficit/Hyperactivity Disorder (ADHD)

Children with ADHD present with significant problems with inattention, impulsiveness and overactivity (Barkley, 1998). Health professionals typically use the criteria listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) as a guideline for determining whether someone has ADHD. This requires the presence of six or more symptoms of inattention, hyperactivity and impulsivity, these symptoms must develop before age seven, and they must significantly impair functioning in two or more settings (such as at home and at school) for a period of at least six months (American Psychiatric Association, 2000).

Parental Stress

In families of children with ADHD the characteristics of the child are thought to be the primary contributor to parenting and family stress (Anastopoulos, Guevremont, Shelton, & DuPaul, 1992). In what Johnston (1990) labelled a "negative-reactive" response pattern, parents of ADHD children display more directive and commanding behaviour, more disapproval, fewer rewards, and more overall negative behaviour than the parents of normal children do (Barkley, Karlsson, & Pollard, 1985; Befera & Barkley, 1984; Cunningham & Barkley, 1979; Mash & Johnston, 1982; Tallmadge & Barkley, 1983).

Family Systems Theory

The social-relations orientation to psychological counselling and therapy, unlike other orientations, has its principle focus on systems. A systems approach asserts the group and the family as its basis, rather than only the individual. From a systems perspective, there are various approaches to family therapy, namely: the Psychodynamic, Structuralist and Strategic approaches (Becvar & Becvar, 1996).

Family Stress Theory

The two models of stress theory that are appropriate for framing this research study are: the Reciprocal Interaction Model of Stress and Hill's ABCX Model of Family Stress as both of these models espouse a systems approach to stress and are relevant to the current

study which is an evaluation of parents' experiences in a stress management programme for parents with ADHD children.

Phenomenology

Phenomenology requires methodologically, carefully, and thoroughly capturing and describing how people experience a phenomenon – how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others (Patton, 1987). To gather such data, requires subjects who have directly experienced the phenomenon of interest.

Triangulation

Using more than one data collection approach permits the evaluator to combine strengths and correct some of the deficiencies of any one source of data. Building checks and balances into a design through multiple data collection strategies is called triangulation. The triangle is the strongest of all geometric shapes, and triangulated evaluation designs are aimed at increasing the strength and rigor of an evaluation (Patton, 1987).

Process Evaluation

Process evaluations focus on gathering descriptive information about the quality of programme activities and outcomes, requiring qualitative data. Thus, to find out what it

means to participate in a particular programme, is an issue of quality and it requires descriptions of the participants' perspective and situation such that the meaning of the experience for the participant is recorded (Patton, 1987). Process evaluation was utilized for this study and it was obtained via a session-by-session analysis of the programme.

Appreciative Inquiry (AI)

AI is a form of action research that attempts to create new ideas and images based on positive experiences that aid in the development of change in a social system. AI enables organizations to increase their capacity to make transformational shifts by moving organizations from a deficit- and problem -based approach to one where organizations learn from their most positive and successful experiences.

METHODOLOGY

The research approach was a qualitative one, namely phenomenology since the focus of this research study was on the experiences of participants in the intervention programme. The sample consisted of 8 participants, 5 mothers and three fathers. The parent stress management group met for 9 consecutive weeks. Each session was two hours in duration.

Process evaluation techniques were utilised in order to evaluate the processes occurring during the course of the programme itself. This was achieved via a session-by-session evaluation of the programme by the researcher. The appreciative inquiry questionnaire

was administered to all participants and a psychologist after termination of the programme. The appreciative inquiry questionnaire asked the following questions:

- Describe your experiences of the programme.

- What do you appreciate about the programme?

- How can this programme be improved?

Confirming data was obtained from the ADHD children of participants via an interview with the researcher. All qualitative data was analysed using thematic content analysis and this was a post-test only design.

RESULTS AND DISCUSSION

Upon close examination of the qualitative data, statements with similar, though not identical, meaning were gathered into categories. To enhance interpretation, key phrases were included. The following key themes emerged:

a) Empowerment

All participants in this study acknowledged the importance of the education and knowledge component of the programme. They believed it helped them feel "less guilty" for their child's condition because they now know what actually causes ADHD and what does not cause ADHD. This in turn helped them to have more realistic expectations for

their children with ADHD. By better understanding their children's behaviour, they changed the way they approached and perceived problem situations. Parents believed that the knowledge and skills which they have acquired through this programme, via the content covered in the sessions has made them feel "empowered and confident, not only in themselves, but in all situations, be it in their home, dealing with others, even at work."

- *"I think it's made me stronger as an advocate and as a parent. I feel more comfortable talking about things that I'm dealing with that might be really upsetting at the time."*

- *"I feel good knowing that I have so much of knowledge on ADHD and the necessary skills to deal with it, such as effective disciplining, dealing with my stress in a better manner, and to be a little more patient when dealing with problems."*

b) Group Cohesion

Through this programme, parents gained increased skills, an increased sense of power and a sense of belonging. Participants were able to connect with each other and provided support and skills to deal with the day-to-day issues of raising a child with ADHD. Participants described the group as a place where everything they were experiencing with their child with ADHD was accepted and understood. The group was perceived as being an open place where participants could express their feelings about living with a child who has ADHD and receive support to help them learn to solve any problems that they

encountered. Participants' experiences of being a member of this group were viewed as extremely positive.

- *"I definitely appreciated the group sessions instead of individual sessions because I was able to learn not only from the facilitator, but also from the others in the group and some of the information I received from other group members was very useful."*

- *"By talking with people in similar situations, it fosters a sense of belonging and promotes hope for me."*

- *"Eventually the group felt like members of my family, we share a common bond so when we are together my problems just don't seem so huge anymore."*

c) Role of Facilitator

The role and skills of the facilitator are fundamental to the effectiveness of the group (Breakwell et al., 1998).

- *"The approach of our leader was very important in this parent stress management programme. It was her initiative and assistance that helped get us to where we are now, which is definitely a far better place than where we had been when we started this programme, and for that I thank her."*

- *"Our group facilitator created the perfect environment for our group. She accepted our differences, she never judged us, she placed no pressure on us to speak, she always listened to every one of our stories whether they pertained to*

the current session or not, she always emphasized the confidentiality issue, and she made us feel comfortable and responsible for the group."

d) Cognitive Restructuring and Behaviour Modification

The whole focus of this programme was to get parents to identify maladaptive patterns of thoughts and behaviours and to replace them with more appropriate ones learned from the programme. The key to doing this was for each participant to think about how their thoughts about a situation or event will influence how they feel and behave.

- *"The first thing that I changed was thinking of my child as ADHD, he is not ADHD, he has ADHD, it is a condition, it is not him. By doing this I managed to separate the diagnosis from my child, the bad behaviours from him, the rudeness from him, etc. and I began to love him and accept him again and became passionate that together he and I can fight this condition."*

- *"By changing the way I always think about my child as being wrong, the causer of problems and uncontrollable, I changed the way I dealt with problem situations in our home. I started understanding him, listening to what he has to say and giving him a fair chance. This changed the way he responded and made the situation easier to resolve. Nowadays, we handle each problem as if it is new and unique, we have no pre-conceived ideas of who did what and who is always wrong, and this has made things so much easier and more peaceful at home."*

f) Change as a Parent and as a Person

A common theme running through parents' experiences of this parent stress management programme is the idea of change. This reflects the idea that people are constantly changing in response to changing situations.

- *"The experiences of this programme have helped me become more assertive in my role as a parent and as a person."*

- *"I have learnt to believe in myself and that nobody knows more about my child than I do and this empowers me."*

- *"I was always blamed for our child's condition and felt maybe it really was my fault. Today, I can say that I am not to blame, there is nothing wrong with me. I may not be a perfect parent but who is?"*

Responses of Psychologist

The psychologist's responses follow:

- **Effective** – *"The parent stress management programme appears to prove effective for mothers and fathers of children with ADHD."*

- **Comprehensive** – *"This programme should be included in the comprehensive management of ADHD. It is easy to understand and user friendly as it involves working directly from the treatment manual."*

- **Adaptability** – *"Although the group format may not be appropriate for all parents, the sessions can be adapted for use with individuals."*

- **Quality** – *"It's nice to read a study that is not bogged down with quantitative measuring instruments and stats. I really enjoyed the qualitative aspect of your approach, to me that is where the real quality lies."*

- **Flexibility** – *"As we discussed, the nice part about this stress management programme is that it is so flexible and comprehensive that it can easily be evaluated either from a qualitative approach (like you have done) or, quantitatively, like the psychologists in New Zealand have done."*

Children's Responses of Observed Behaviour Changes in Parents

The children were asked only one question: *"You do know that your mum and dad/mum only has been attending a parent programme for several weeks now. Have you noticed any changes in them, or the way they now interact/respond to you? Can you please tell me about them?"*

All the children that were interviewed commented on the following improvements:

Relaxed

- *"I love my mummy the way she is now, she's calmer and more relaxed. Her headaches have stopped and she's not taking any more pills. She used to shout a lot at me and dad but now she's better. I hope she still comes to you."*

- *"I can talk to mummy now without us fighting, she's more understanding and has stopped shouting at me for everything. Did you give her some pills to be calm? Can I have some for later, in case she starts getting cross again, I can give her the pills?"*

Approachable

- *"Before, when I used to do something wrong, or get into trouble for something I would never tell my mum because she would make it worse. She would shout at me and make me cry, even when it wasn't my fault. Now, she speaks to me nicely and I feel I can tell her stuff."*

Loving

- *"I always thought that I was adopted because I was different from my brothers and I knew that my parents didn't love me. These days I think they love me more than the others."*

Included

- *"Now they care about me, they do stuff with me."*
- *"We now have new rules at home which we all made together, me too, because I am also in this family, dad said that and we must follow the rules."*

Despite all of these positive comments, participants believed that this programme can be improved. They made several suggestions such as: separate groups for mothers and

fathers, inclusion of a session with child with ADHD, funding for childcare whilst parents attend the programme, more sessions, and inclusion of the school component in the programme.

IMPLICATIONS FOR FUTURE RESEARCH

First off, the suggestion for administering the programme to a separate group for mothers and another one for fathers is worthy of discussion. While the researcher acknowledges that by including both, mothers and fathers from the same family in the group created tension and discomfort amongst other participants when the spouses disagreed and were involved in heated arguments, the reason behind including both spouses was to get a more holistic view of the interactions between parents and their children with ADHD.

Traditional family roles, in which mothers do all the nurturing and fathers withdraw into outside work activities, leave mothers overly responsible for the emotional health of all members of the family. Many family researchers recommend sharing the role of nurturing as they have found that traditional roles contribute to dysfunction due to the alienation of the father in the emotional life of the family and the over-functioning of the mother in an impossible attempt to make everyone happy. By including both spouses, it was a step towards sharing parenting responsibilities and it also served to illustrate how differently mothers and fathers reacted to and dealt with the stress around parenting their ADHD children.

The suggestion of including the child with ADHD in at least one session is also an important point, however, the focus of this programme was not on changing actual child behaviours, therefore the children were not included in any session, the focus was on changing parents' perceptions, thoughts and behaviours. Most of the research studies to date have focused on the child with ADHD with very few studies only recently beginning to realise the impact of having an ADHD child on parents' psychological and emotional well being.

Considering the field of education in South Africa is moving towards the inclusion of learners with special needs into mainstream, more in-service training programmes accessing information about the management of learners diagnosed with ADHD should be provided to mainstream educators. Including the school component in the programme would definitely have addressed parents' concerns regarding their child and interactions with the school personnel. As some parents have stated that their child's school is a major source of stress for them. By school personnel understanding ADHD and the impact it has on the child and his or her family, teachers can become more sensitive and empathic in their interactions with these families. As has already been stated by participants in this study that their children's teachers did not appear to have much experience in working with learners who had ADHD, it seems reasonable to recommend that more training on ADHD occur in teacher training programmes.

One of the possible limitations of this study is that the researcher and the participants shared the same cultural context, therefore the results may not be applicable to persons

from a different culture. Little is known about ADHD on the African continent because of the lack of resources, problems in access and communication and political strife. The recognition of culture and ethnicity are extremely important in the development of ADHD, as culture shapes the environment in which behaviour is defined as inappropriate (Madu, 2003).

A further limitation is the fact that only three participants were male while 5 were females. This questions whether the primary care-taking role belonged to mothers, possibly contributing to their greater distress.

No objective measure of parent functioning was included in this study. Given the significant improvements in parenting style, together with the reported links between parenting stress, parenting practices, and the parent-child relationship, future studies should include objective measures of parent-child interaction quality and parenting style.

Although the parent responses indicate that the programme was successful in achieving its goals, these results are appropriate for a single moment in time, immediately following the completion of the programme. To assess whether significant treatment effects were mainstreamed, six and 12 month follow-up data need to be collected and analysed from the participants in this programme.

CONCLUSION

Despite these limitations, the results of the study suggest that the Parent stress Management Programme for Parents with ADHD children is effective. The negative effects of elevated parenting stress on the parent-child relationship and parenting practices argues for the inclusion of such programmes in the comprehensive management of ADHD. Treatment for ADHD should focus on enhancing parents' coping resources as well as directly targeting the child's symptoms and associated difficulties. Reducing parent distress may also help increase the effectiveness of other treatment components, including parent management training (Webster-Stratton, 1990).

The current study is the first to target the parenting stress of parents of children with ADHD so directly (Treacy et al., 2005). In doing so it makes two important contributions to the field. First, it draws attention to the needs of parents of children with ADHD. While widely acknowledged, the difficulties of parents of children with ADHD are seldom the focus of intervention. Secondly, the programme components, while not unique, together offer an innovative and promising approach to the comprehensive management of ADHD.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders*. (4th ed. Text Revision). Washington DC: APA.

Anastopoulos, A.D., Guevremont, D.C., Shelton, T.L., & DuPaul, G.J. (1992). Parenting stress among families with attention deficit hyperactivity disorder. *Journal of Abnormal Child Psychology, 20, 503-520.*

Anastopoulos, A.D., Shelton, T.L., DuPaul, G.J., & Guevremont, D.C. (1993). Parent training for attention deficit hyperactivity disorder: Its impact on parent functioning. *Journal of Abnormal Child Psychology, 21, 581-596.*

Barkley, R.A., Karlsson, J., & Pollard, S. (1985). Effects of age on the mother-child interactions of hyperactive children. *Journal of Abnormal Child Psychology,* 13: 631-638.

Barkley, R.A. (1998). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (2nd ed.). New York: The Guilford Press.

Barkley, R.A., Guevremont, D.C., Anastopoulos, A.D., & Fletcher, K.E. (1992). A comparison of three family therapy programs for treating family conflicts in adolescents with attention deficit hyperactivity disorder. *Journal of Consulting and Clinical Psychology, 60, 450-462.*

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Becvar, D.S. & Becvar, R.J. (1996). *Family Therapy: A Systemic Integration.* Boston: Allyn and Bacon.

Befera, M. & Barkley, R.A. (1984). Hyperactive and normal girls and boys: mother-child interactions, parent psychiatric status, and child psychopathology. *Journal of Child Psychology and Psychiatry,* 26: 439-452.

Breakwell, G.M., Hammond, S., & Fife-Schaw, C. (1998). *Research Methods in Psychology.* London: SAGE Publications Ltd.

Chronis, A.M., Pelham, W.E., Roberts J.E., Gamble, S.A., Gnagy, E., & Burrows-Maclean, L. (1999, November). *Two approaches to managing stress in parents of children with ADHD.* Poster session presented at the annual meeting of the Association for Advancement of Behavior Therapy, Toronto.

Cunningham, C.E., & Barkley, R.A. (1979). The interactions of normal and hyperactive children with their mothers in free play and structured tasks. *Child Development,* 50: 217-224.

Fischer, M. (1990). Parenting stress and the child with attention deficit hyperactivity disorder. *Journal of Clinical Child Psychology,* 19, 337-346.

Henker, B. & Whalen, C.K. (1989). Hyperactivity and attention deficits. *American Psychologist,* 44: 216-223.

Johnston, C. (1996). Parent characteristics and parent-child interactions in families of non problem children and ADHD children with higher and lower levels of oppositional-defiant disorder. *Journal of Abnormal Child Psychology*, 24: 85-104.

Kazdin, A.E. & Whitley, M.K. (2003). Treatment of parental stress to enhance therapeutic change among children referred for aggressive and antisocial behaviour. *Journal of Consulting and Clinical Psychology.* 71 (3): 504-515.

Mash, E.J. & Johnston, C. (1982). A comparison of motherhood interactions of younger and older hyperactive and normal children. *Child Development*, 53: 1371-1381.

Mash, E.J., & Johnston, C. (1990). Determinants of parenting stress, illustrations from families of hyperactive children and families of physically abused children. *Journal of Clinical Child Psychology*, 19: 313-328.

Patton, M.Q. (1987). *Qualitative research and evaluation methods* (3rd ed.). Newbury Park, CA: Sage Publications, Inc.

Rabiner, D. (2002). Stress and coping in parents of children with ADHD. *Attention Research Update*. Available online at: http://www.helpforadd.com (Retrieved January 2007).

Santrock, J.W. (2002). *Life-span development.* New York: Mcgraw-Hill Companies.

Swensen, A.R., Birnbaum, H.G., Secnik, K., Marynchenko, M., Greenberg, P., & Claxton, A. (2003). ADHD: Increased costs for parents and their families. *American Academy of Child and Adolescent Psychiatry.* 42 (12): 1415-1423.

Tallmadge, J. & Barkley, R.A. (1983). The interaction of hyperactive and normal boys with their mothers and fathers. *Journal of Abnormal Child Psychology*, 11: 565-579.

Treacy, L., Tripp, G., & Baird, A. (2005). Parent Stress Management Training for Attention-Deficit/Hyperactivity Disorder. *Behaviour Therapy*, 36: 223-233.

Weinberg, H.A. (1999). Parent training for attention deficit hyperactivity disorder: Parental and child outcome. *Journal of Clinical Psychology*, 55, 907-913.

Wells, K.C., Epstein, J.N., Hinshaw, S.P., Conners, C.K., Klaric, J., Abikoff, H.B., Abramowitz, A., Arnold, L.E., Elliott, G., Greenhill, L.L., Hechtman, L., Hoza, B., Jensen, P.S., March, J., Pelham Jr., W., Pfiffner, L., Severe, J., Swanson, J., Vitiello, B., & Wigal, T. (2000). Parenting and family stress treatment outcomes in attention deficit hyperactivity disorder (ADHD): An empirical analysis of the MTA study. *Journal of Abnormal Child Psychology*, 28, 543-553.